

SOUTHWEST LICKING LOCAL SCHOOLS
PHYSICIAN'S REPORT

PARENTS – PLEASE COMPLETE THIS SIDE

CHILD'S NAME _____ BIRTHDATE _____

ADDRESS _____
P.O. BOX _____ STREET _____ CITY _____ ZIP _____

PHONE NUMBER (____) _____ BIRTHPLACE _____

MOTHER'S NAME _____
LAST FIRST MAIDEN

MOTHER'S EMPLOYER _____ WORK PHONE _____

FATHER'S NAME _____
LAST FIRST MIDDLE

FATHER'S EMPLOYER _____ WORK PHONE _____

PHYSICIAN'S NAME _____ PHONE _____

PHYSICIAN'S ADDRESS _____

LIST ANY OTHER PERTINENT FAMILY INFORMATION _____

CHILD'S HISTORY:

ALLERGIES _____

MEDICATIONS _____

OPERATIONS & DATES _____

PHYSICAL PROBLEMS _____

DIEASES _____

PLEASE LIST ANY OTHER INFORMATION THE TEACHER OR NURSE NEEDS TO KNOW IN ORDER TO UNDERSTAND THIS STUDENT BETTER OR HELP HIM/HER IN ANYWAY. _____

PLEASE LIST THE NAMES OF ANY BROTHERS OR SISTERS AND BIRTHDATES.

THIS SIDE TO BE COMPLETED BY PHYSICIAN

CHILD'S NAME _____ DATE OF BIRTH _____

1 – HEAD & NECK _____

2 – HEART & LUNGS _____

3 – ABDOMINAL _____

4 – EXTREMITIES _____

5 – WEIGHT _____ HEIGHT _____

6 – VISION RIGHT LEFT DATE

MUSCLE BALANCE _____

FARSIGHTEDNESS _____

COLOR _____

DISTANCE ACUITY _____

7 – HEARING _____

8 – ANY ABNORMALITIES OR ALLERGIES _____

IMMUNIZATIONS – PLEASE ENTER DATE – MONTH, DAY, AND YEAR = required for school entry

DPT	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TD	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MMR	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HEPATITIS B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
VARICELLA	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HIB-d (prior to age 5 only)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TUBERCULIN TEST	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
OTHER	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

IS THERE ANY REASON WHY THIS STUDENT CANNOT CARRY OUT A FULL PROGRAM OF SCHOOL WORK? YES _____ NO _____

SIGNATURE OF EXAMINING PHYSICIAN/CERTIFIED NURSE PRACTITIONER	DATE OF EXAMINATION
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NAME OF EXAMINING PHYSICIAN/CERTIFIED NURSE PRACTITIONER	TELEPHONE NUMBER
STREET ADDRESS	
CITY, STATE, ZIP CODE	