

PERKINS SCHOOL HEALTH RECORD PHYSICIAN'S REPORT

Date of Exam _____

Child's Name _____ Male _____ Female _____ Age _____ Date of Birth _____

OBJECTIVE DATA:

Height _____ (%) Weight _____ (%) B.P. _____ / _____

SCREENING TESTS: Date Done _____

Vision

Distance Acuity R _____ L _____
 Muscle Balance pass _____ fail _____ not done _____
 Farsightedness pass _____ fail _____ not done _____
 Color pass _____ fail _____ not done _____
 Child wears glasses? yes _____ no _____
 Tested with glasses? yes _____ no _____
 Referral made? yes _____ no _____

Hearing Date Done _____

Audiometric thresholds:
 R - ear pass _____ fail _____ not done _____
 L - ear pass _____ fail _____ not done _____
 Other test (specify) _____

 Child wears hearing aid? yes _____ no _____
 Tested with hearing aid? yes _____ no _____
 Referral made? yes _____ no _____

SPEECH/LANGUAGE

Speech assessment: done _____ not done _____
 Child has no discernible speech problem _____
 Child has possible problem with: _____
 Disorders: (check) Articulation _____ Rhythm _____ Voice _____ Language _____
 Speech evaluation recommended: yes _____ no _____

PHYSICAL EXAMINATION: Date examined _____ Essentially normal _____ Abnormalities as follows:

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement, or attention? _____

PHYSICIAN'S ASSESSMENT

Problem list	Recommendation for school management
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

PLEASE PRINT OR STAMP

Physician's name _____ Physician's signature _____

Address _____

Phone _____ Date signed _____