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 behavorial 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 _____

4/04