MEDICAL EXAMINATION REPORT

Student's Name (Last, First, Middle) _____ Birthdate _____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Parent(s)/Guardian(s) Names(s) _____ Phone _____

School (or previous school, if not yet enrolled in APS) _____ Grade _____

Printed Name and Signature of Referring Party _____ Date _____

TO BE COMPLETED BY THE PHYSICIAN (M.D. or D.O.)

Diagnosis/Summary of Medical History _____

Current Medication (if any)/Notable Side Effects _____

Check all descriptions which may interfere with this student's school functioning:

_____ Frequent absences
_____ Lack of strength
_____ Lack of vitality
_____ Lack of alertness

Limited ability to: _____ move about
_____ sit
_____ manipulate materials

Sensory impairment(s) resulting in:
_____ limited vision
_____ limited hearing
_____ limited vision and hearing

Skeletal deformities affecting: _____ ambulation
_____ posture
_____ body use

Additional information regarding this student's disabling condition _____

Description of special health care or emergency procedures, if applicable: _____
_____
_____

Surgical History: Type of Surgery Date Results
_____
_____
_____

Prognosis/Precautions: _____
_____
_____
_____

Speech Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A
Occupational Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A
Physical Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A

Special instructions regarding physical, occupational, and/or speech therapies: _____
_____
_____
_____
_____
_____

If applicable, name(s) and address(es) of other physicians or medical agencies providing health care to student: _____
_____
_____
_____

_____
Physician's Signature

_____
Physician's Name (Print or Type)

_____
Name of Clinic/Health Facility, if applicable

_____
Address

_____
Date

Return to: _____
_____
_____
_____