LOS ANGELES UNIFIED SCHOOL DISTRICT - EXAMINATION BY PRIVATE PHYSICIAN

Name _____ Sex: M___ F___ Birth Date: _____

Address _____ School _____

To the Physician: Please complete both sides and return to the child's school in attached envelope.

BIRTH HISTORY: (Optional)

Pre-natal Complications _____

Birth Weight _____ Delivery _____

Neo-natal Complications _____

DEVELOPMENTAL MILESTONES:

Sat_____ mo. Crawl _____mo. Walked _____mo.

Words_____mo. Sentences_____ mo.

Toilet Trained _____ mo.

MEDICAL HISTORY:

Serious Illnesses or injuries _____

_____

_____

Surgery

Allergic Reactions _____

IMMUNIZATIONS OF (NUMBER DOSES AND DATES):

DPT 1 2 3 4 5

or

TD 1 2 3 4 5

Polio 1 2 3 4 5

Measles _____

Mumps _____

Rubella _____

H.I.B. _____

Hepatitis B _____ (over)

Other _____

(N= Normal O= Over for Comment.)

	Under RX
Date of Examination	
Wt. _____ Ht. _____	
Eyes _____ Vision R:20/ L:20/	
Ears _____ Hearing _____	
Nose _____	
Mouth _____ Speech _____	
Throat _____ Tonsils _____	
Teeth _____ Orthodontia Needed _____	
Heart _____ B.P. _____	
Lungs _____	
Abdomen _____ Hernia _____	
G-U _____	
Nervous System _____	
Skin _____	
Posture _____	

(Please indicate deviations from normal)

Other Orthopedic _____

_____

Blood _____ Urine _____

Mantoux Test: Given _____ Read _____

Pos._____ (date) (date)

(Indur. mm) Chest X-ray_____ Results: _____

Neg. _____ (date)

EXAMINATION BY PRIVATE PHYSICIAN (continued)

Currently does this child need help with:

Motor Development _____

Speech _____

Behavior _____

Emotional Growth _____

Has this child had:

Psychological Testing _____

Neurological Referral _____

Psychiatric Referral _____

Other Counseling _____

Current Medication: No _____ Yes _____ What _____

_____

PARENTAL REQUEST: I request that my physician release this completed report to the school.

_____

Parent/Guardian Signature Date

PLEASE Return To:

School _____

Address _____

City _____ Zip _____

Form No. 34-AEH-51

Commodity Code No. 966 12 15306 Repro

Recommendations and Comments:

(Physical Education required by State Law):

Reg. _____

Limited or Adaptive _____ Why _____

_____

_____

_____

Signature _____ M.D.

_____ M.D.

(Please type or print name)

Address _____

Phone _____ Date _____