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 _____

Varicella _____

(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)
Neg. _____ Chest X-ray _____ Results: _____
(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**