ATLANTA PUBLIC SCHOOLS
Making A Difference

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_____
_____
_____
_____
_____

 Student: _____

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: _____
_____
_____
_____