Confidential

MEDICAL DIAGNOSITIC EVALUATION FORM

Identifying Data Date: ______/______/______

Child's Name: ____________________ Age: __________ Grade: __________

Parent's Name: ____________________ School: __________

Address: ____________________ District: __________

I. General Findings

Significant findings on (describe any abnormalities):

A. General physical examination

Height __________ Weight __________ BP __________ Lymphatics __________

Skin __________ Head __________ Eyes __________ Ears __________

Nose __________ Teeth __________ Neck __________ Chest __________

Back __________ Abdomen __________ Genitalia __________ Extremities __________

B. Vision

C. Speech and hearing

II. Specific Findings

Significant findings:

A. General neurological examination

Gait __________ Station __________ Muscle Power __________

Muscle Tone __________ Reflexes __________ Cranial Nerves __________

❖Denotes optional procedure/form

B. Motor abnormalities

Gross Motor Coordination: ______________________________

Fine Motor Coordination: ______________________________

C. Sensory abnormalities

III. Behavioral Problems (check if observed or reported by informant)

☐ Hyperactive ☐ Withdrawn ☐ Short attention span ☐ Disturbed sleep pattern

☐ Distracted ☐ Other (please describe) ______________________

IV. Medications Prescribed:

V. Medical Recommendations:

VI. DIAGNOSIS: ______________________________

____

VII. This is to certify that the above-named child has had a complete physical examination.

______________________ ______________________

Physician's Signature Date

____

Physician's (Printed) Name

____

Physician's (Printed) Address

____

Physician's (Printed) Address

____

Physician's (Printed) Telephone Number

❖Denotes optional procedure/form