Physician's Medical Report

Student's Name ______________________ D.O.B. ________ Age _____ Sex __________

Parent/Guardian ____

Address ____________________________________ Phone __________

School Nurse ____

School ____

Address ____________________________________ Phone __________

Diagnosis

1. External Ear

Clear:	_____ Right	_____ Left
Cerumen:	_____ Right	_____ Left
External Otitis	_____ Right	_____ Left

Other: (Please describe) ____

____

2. Middle Ear

Clear:	_____ Right	_____ Left
Retracted TM:	_____ Right	_____ Left
Fluid:	_____ Right	_____ Left
Otitis Media:	_____ Right	_____ Left

Other: (Please describe) ____

____

Medical Confirmation of Hearing Loss: Yes______ No______

Treatment Plan (Check where appropriate)

	Date	Right Ear	Left Ear
Removed Cerumen	______	______	______
P.E. Tubes	______	______	______
Myringotomy	______	______	______
Tonsillectomy	______		
Adenoidectomy	______		

No Treatment Necessary ____

Medication Prescribed (Specify type, dosage and duration and possible effects on school performance) ____

____

____

____

Follow-Up Plan:

Referrals

_____ Otolaryngologist _____ School Nurse _____ Audiologist
_____ Speech and Language Pathologist
_____ Other (specify ___________________________)

Management Plan

_____ No follow-up necessary
_____ Schedule for medical recheck (Date__________)
_____ Schedule for surgery (Date__________)
_____ Inform school nurse of medical findings
_____ Periodic pure tone screening by school personnel
_____ Periodic acoustic immittance screening by school personnel

Other Comments:

____
Physician's Signature

____
Address

____
Phone

Please forward this report to the school nurse at the address on the front page. Thank you for your cooperation.