# LSDVI MEDICAL REPORT
## TO BE COMPLETED BY DOCTOR OR LICENSED PRACTICTIONER

| Student Name: | Date of Birth: | Ht: | Wt: | BMI: | BP: | P: | Resp: | Temp: |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| Review of Systems | WNL | ONL | Comments | Physical Exam Findings | WNL | ONL | Comments |
|---|---|---|---|---|---|---|---|
| Eyes | | | | Skin | | | |
| ENT | | | | Head | | | |
| CV | | | | Eyes | | | |
| Respiratory | | | | ENT | | | |
| GU | | | | Mouth/Teeth | | | |
| GI | | | | Neck | | | |
| Musculoskeletal | | | | Chest | | | |
| Integumentary | | | | Heart | | | |
| Neurological | | | | Lungs | | | |
| Psychiatric | | | | Abdomen | | | |
| Endocrine | | | | Genitalia (Tanner Stage) | | | |
| Hemo/Lymphatic | | | | Bones, Joints, Muscles | | | |
| Allergic/Immuno | | | | Neurological | | | |

**MEDICAL DIAGNOSIS (ALL):**_____

_____

**Any surgeries/hospitalizations in past year? If so, explain:**_____

**Does the student have any of the following medical devices?**

| | | | |
|---|---|---|---|
| ☐ Tubes in ears (PE Tubes) | ☐ VP Shunt | ☐ Pacemaker | ☐ Dialysis Shunt |
| ☐ Tracheostomy | ☐ Gastrostomy/Feeding tube | ☐ Central Line | ☐ Vagal Nerve Stimulator |
| ☐ Cochlear Implant ☐ Right ☐ Left | | ☐ Prosthetic Eye ☐ Right ☐ Left | |
| ☐ Other (please list): | | | |

**Any activity restrictions? (PE, competitive sports, etc.) ☐ No ☐ Yes**
**If yes, please specify:**

**Any classroom modifications? (bathroom privileges, etc.) ☐ No ☐ Yes**
**If yes, please specify:**

**Immunizations up-to-date. ☐ Yes ☐ No - Provide signed letter exempting student from required vaccines.**

**Does student take ANY medications?**

**☐ No - Student takes NO medication**

**☐ YES – List ALL meds(attach Med Order Form if to be given at school/dorm):**

**Medication(s):**_____

_____

_____

******Note to provider:* **–** *We are a partial **RESIDENTIAL** school. This student may live on campus in Baton Rouge, LA. If **ANY** medication is prescribed (Scheduled or PRN, RX or OTC including vitamins & dietary supplements) complete medication orders must be provided on the attached Medication Order Form in accordance with R.S. 17:436.1 (2001).*

| Allergies:(drug/food/latex/insect/environmental) | Type of reaction: |
|---|---|
| 1 | 1 |
| 2 | 2 |

**Is EPI-PEN required? ☐ No ☐ Yes** - Attach med order as applicable

**Any special diet restrictions? ☐ No ☐ Yes**
**If yes, please specify:**

**Medical clearance for Sunscreen to be provided by school: ☐ No ☐ Yes**

| Practitioner's Signature | Today's Date: | Office Stamp Required: | Mail or Fax to: |
|---|---|---|---|
| | Phone: | | LSDVI Student Health Ctr.<br>2888 Brightside Drive<br>Baton Rouge, LA 70820 |
| **PRINT** Practitioner Name | Fax: | | Phone (225) 757-3247<br>Fax (225) 757-3430 |

Revised 3/7/2018