

LSDVI MEDICAL REPORT
TO BE COMPLETED BY DOCTOR OR LICENSED PRACTITIONER

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

<input type="checkbox"/> Tubes in ears (PE Tubes)	<input type="checkbox"/> VP Shunt	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Dialysis Shunt
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Gastrostomy/Feeding tube	<input type="checkbox"/> Central Line	<input type="checkbox"/> Vagal Nerve Stimulator
<input type="checkbox"/> Cochlear Implant	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Prosthetic Eye	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> 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: _____

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