

GATEWAY SCHOOL

2570 N.W. Green Oaks Blvd.
Arlington, TX 76012
Metro 817-226-6222
Fax 817-226-6225

PHYSICIAN'S REPORT

Student's Full Name _____

First
Middle
Last
Nickname

Date of Birth _____ Sex: M F
mm/dd/yyyy

Height _____ inches Weight _____ lbs Underweight Overweight

BP: _____ / _____ High Low

Hearing: _____ R _____ L Within Normal Limits? _____

Vision 20/ _____ R 20/ _____ L Corrected? Yes No

Scoliosis Exam Pass Refer Observe

Immunizations: Please list all dates of immunization or date of illness:

DTP/DT/Td						
Oral Polio Vaccine						

Measles		
Mumps		
Rubella		
HibCV		

GATEWAY SCHOOL

2570 N.W. Green Oaks Blvd.
Arlington, TX 76012
Metro 817-226-6222
Fax 817-226-6225

Any abnormality of these systems?	Yes	No
Head, Ears, Nose, or Throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

Does the student have any severe allergies? _____

Is the student allergic to any medications? _____

Please fully describe any existing physical or emotional conditions, medications prescribed, etc. and any general comments you may have concerning the student. Attach additional pages as necessary.

Recommendations for physical activity (PE, sports, school activities) Unlimited Limited

Explain limitations _____

GATEWAY SCHOOL

2570 N.W. Green Oaks Blvd.
Arlington, TX 76012
Metro 817-226-6222
Fax 817-226-6225

Remarks: _____

If student has had a physical check-up within the last 12 months, please date and fill in all of the data. Thank you.

Physician's Signature _____ Date _____
mm/dd/yyyy

Print Last Name _____