Physician's Report Form

to be returned to:
Pewaukee Lake Elementary School
436 Lake Street
Pewaukee, WI 53072

Name of Student: ______________________________ Date of Birth: ________________

Name of Parents: ______________________________

Address: ____

Significant medical concerns: ____

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____

Allergies to: food, medicines, latex, environmental Yes _______ No _______

If yes, please include information on care or treatment: ______________________________

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Need for any specific medical, dental, psychiatric, or surgical care including immunization: Yes ___ No ___
If yes, please include information on care or treatment:

____

____

Hearing: R _______ L _______ Comments: ______________________________

Vision: - see below:

<u>Included in 2001 Wisconsin Act 16:</u> Requires each student entering kindergarten to provide evidence that the student has had his/her eyes examined by an eye care professional or a physician.

Visual Acuity:	At Distance		At Near	
☐ without correction........................	R 20/____	L 20/____	R 20/____	L 20/____
☐ with present correction..................	R 20/____	L 20/____	R 20/____	L 20/____
☐ with new correction.......................	R 20/____	L 20/____	R 20/____	L 20/____

External Eye Health:
☐ Normal ☐ Other

Internal Eye Health:
☐ Normal ☐ Other

Vision Analysis:
☐ Normal Eyesight
☐ Eye Teaming Difficulty
☐ Crossed-eyes (strabismus)
☐ Focus Difficulty
☐ Other ______________________________

	Right eye	Left eye
Nearsighted (myopia)	☐	☐
Farsighted (hyperopia)	☐	☐
Astigmatism	☐	☐
Lazy Eye (amblyopia)	☐	☐

Glasses to be worn:
☐ At all times ☐ For school work ☐ Distance vision ☐ Near Vision

Signature of Eye Care Provider (if other than physician) ______________________________ **(over)**

Is the pupil incapable of carrying a full program of school work? Yes ______ No ______

Is special seating recommended? Yes ______ No ______

Does pupil have irremediable defects? Yes ______ No ______

Is there evidence of emotional or behavioral problems? Yes ______ No ______

Is there a need to restrict physical educational activity Yes ______ No ______

Should physical activity outside of school be limited? Yes ______ No ______

List any recommendations or restrictions from normal activity including nature and duration:

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______________________________________ ______________________________
(Signature of Physician) (Date)

____
(Address)

______________________________ ______________________________
(Phone #) (Fax #)

kgn/physicianform (revised January 2006)