H. Serv.

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REPORT ON CHILD WITH RESPIRATORY DYSFUNCTION

____
(Last Name) (First) (Middle) (BD) (ID Number))

____
Home Address Zip Code Other Town

____
Father's Name Mother's Name Telephone

____
School Grade Non-Attending

Dear Doctor,

The School Nurse of Chicago Public Schools has requested your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files.

Date_________________________________ School Nurse____

DIAGNOSIS (Please Specify) ____

HISTORY (date of onset, contributing or causative factors, medical/surgical) ____

____

____

RECOMMENDATIONS

1. Current procedures utilized to maintain optimal respiratory function (check all that apply)

____Oxygen ____Mask ____Nasal cannula Setting__________________________________

____Suctioning Type____

____Tracheostomy Type____

____Percussion ____Vibration ____Postural drainage ____Controlled coughing

____Mechanical ventilation Type____

Settings____

____Nebulizer treatments____

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

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2. Medications (include type, dose, time, and side effects)____

   ____

   ____

3. Restrictions: (check proper recommendation)

   ____Physical activity need not be restricted

   ____Ordinary physical activity need not be restricted (may participate in gym, but should not engage in severe or competitive physical efforts)

   ____Ordinary physical activity restricted (advise against physical education)

   ____Ordinary physical activity should be markedly restricted

   (Please explain)____

   ____

   ____

   ____Should be at complete rest

4. Additional recommendations:

   Diet: ____

   Other: ____

   ____

LATEST PHYSICAL FINDINGS

Weight___________ Height___________ Blood pressure___________ Pulse______________

Respiratory rate_____________ Rhythm__________ Depth_________ Skin color_______________

Breath sounds_________________ Cough_________________ Sputum______________________

Physician's Name ____________________________________**Hospital Affiliation** ______________________
(Please print or type)

Address _________________________________**Telephone #** ________________ **Fax #**_______________

Physician's Signature ____ **Date** ____________________