ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN'S REPORT ON CHILD WITH RESPIRATORY DYSFUNCTION

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

Home Address Zip Code City

Parent/Guardian Telephone (home) Telephone (cell)

School Grade/Div 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 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_____

_____Other_____

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

_____

_____

3. Restrictions: (check 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

(Explain)_____

_____

_____

____Complete rest until _____

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** _____