

ALBEMARLE COUNTY PUBLIC SCHOOLS
MEDICAL FOLLOW-UP FORM FOR PHYSICIAN

Please Return to: **Speech-Language Pathologist** _____

School Address _____

Phone _____

Student: _____ **DOB:** _____

School: _____ **Grade:** _____ **Date:** _____

1. Historical Information:

- Have you ever treated this child for otitis media? Yes No
- Do you consider this child to have chronic or recurrent otitis media? Yes No

2. Results of Examination: _____

3. Treatment: (Check all that apply)

- None Observation Medication P.E. Tubes Other

4. Recommendation:

Follow-up: Yes No If "Yes", please specify date: _____

Referral(s): _____

Other: _____

5. Audiological Evaluation: (Please attach results of audiogram / tympanogram)

Pure Tone

	500	1K	2K	4K		
Right						
Left						

Physician: _____ **Date:** _____

Address / Phone: _____
