College of Health and Human Services
School of Speech, Language, and Hearing Sciences

Speech-Language Clinic
5500 Campanile Drive, San Diego, CA 92182-1518
619-594-7747
FAX: 619-594-7790

MEDICAL INFORMATION FORM

A request has been made for _____ to be seen for a speech-language or hearing evaluation at the San Diego State University Communications Clinic. It is necessary for us to have medical clearance, as well as knowledge of all relevant medical findings, to facilitate our evaluation and recommendations. Only **after** we receive this form will the applicant be eligible for speech-language evaluation or therapy.

TO BE COMPLETED BY APPLICANT/PARENT/GUARDIAN:

Name of Applicant_____Date of Birth_____

_____

(Authorization Signature for release of information) (Date)

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TO BE COMPLETED BY PHYSICIAN:

Date Client examined_____
Height_____Percentile for Age_____
Weight_____Percentile for Age_____
General Appearance_____
Central Nervous System_____
Posture/Gait_____
Motor Abilities_____
Eyes_____
Ears_____
History of Ear Infections/Treatment_____

_____
Teeth_____
Tonsils/Adenoids_____
Lingual Frenum_____
Heart/Lungs_____
Abdomen_____
Nutrition_____
Allergies_____
Current Medications_____
In your professional opinion, are there aspects of the applicant's medical status or history that would affect his/her communication abilities? Yes_____ No____
If yes, please explain:_____

_____
Additional Remarks:_____

_____

Please Print: Physician's Name_____
Specialty_____Phone_____

_____
Address_____

_____
May we contact you if we have questions? Yes____ No_____

_____
(Date) (Examining Physician's Signature)