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)

Form 1.g (rev. 7/22)