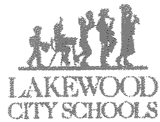

PHYSICIAN'S MEDICAL REPORT TO SCHOOLS

[To Be Completed By Student's Physician & Returned to School]

Student's Name:_______________________________ DOB:___________________________

I. MEDICAL HISTORY:

Chronic Medical Conditions: ☐ Asthma ☐ Diabetes ☐ ADHD ☐ Seizure ☐ Other: ____________________

Medications (with dose/frequency): ☐ NONE ____

____

Allergies: ☐ NONE ____

Development:

Physical	☐ normal	☐ abnormal: ____________________
Behavioral	☐ normal	☐ abnormal: ____________________
Sensory	☐ normal	☐ abnormal: ____________________
Social	☐ normal	☐ abnormal: ____________________
Language	☐ normal	☐ abnormal: ____________________

III. PHYSICAL EXAM/TESTS:

Height: ____________ Weight: ____________ BP: ____________ BMI (%ile): ____________

Examination date: __________ ☐ normal ☐ abnormal (comments): ______________________________________

Vision: ☐ N/A RIGHT: ____/20 LEFT: ____/20 BOTH: ____/20 ☐ corrected ☐ uncorrected

Hearing: ☐ N/A ☐ normal ☐ abnormal: __________

Hemoglobin/HCT: ☐ N/A ☐ normal ☐ abnormal: __________ Lead: ☐ N/A ☐ normal ☐ abnormal: __________

Urinalysis: ☐ N/A ☐ normal ☐ abnormal: __________ TB test: ☐ N/A ☐ normal ☐ abnormal: __________

IV. RECOMMENDATIONS:

Is this child able to participate fully in:

Classroom and academic activities ☐ YES ☐ NO Competitive athletics ☐ YES ☐ NO

Physical education classes ☐ YES ☐ NO Contact and collision sports ☐ YES ☐ NO

If limitations are advised, please specify:____

V. PHYSICIAN INFORMATION (print or stamp):

Physician's Name: ____ Date: __________________________

Address: ____

Phone Number: ____

Fax Number: ____

Signature: ____

Lakewood Community Recreation and Education Fax: 216-529-4464

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