



# PHYSICIAN'S MEDICAL REPORT TO SCHOOLS

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## I. MEDICAL HISTORY:

Chronic Medical Conditions: Asthma Diabetes Severe Allergy Seizure Other: \_\_\_\_\_

Medications (with dose/frequency): NONE \_\_\_\_\_

Allergies: NONE \_\_\_\_\_

<u>Development:</u>	Physical	normal	abnormal:	_____
	Behavioral	normal	abnormal:	_____
	Sensory	normal	abnormal:	_____
	Social	normal	abnormal:	_____
	Language	normal	abnormal:	_____

## II. 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:	_____

## III. 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: \_\_\_\_\_

## IV. PHYSICIAN INFORMATION (print or stamp):

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Lakewood Community Recreation & Education  
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Scan/Email to [info@lakewoodrecreation.com](mailto:info@lakewoodrecreation.com)