LAKEWOOD CITY SCHOOLS

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 _____

Development:			
	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
Fax Number: (216) 529-4464 or
Scan/Email to info@lakewoodrecreation.com