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 ____

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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