

**MEDICAL REPORT**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  Male  Female School: \_\_\_\_\_

REASON FOR REFERRAL: Preschool Kindergarten First Grade Middle School High School Special Placement Athletics

FOR THE FOLLOWING OBSERVATIONS: \_\_\_\_\_

Referred by: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

----- **HEALTH HISTORY TO BE COMPLETED BY PARENT** -----

Currently under the care of: \_\_\_\_\_ For what condition? \_\_\_\_\_  
*PHYSICIAN'S NAME* *MEDICATION* (name and dosage of any medication your child is taking):

Currently under the care of: \_\_\_\_\_  
*DENTIST'S NAME*

**\*PARENT'S AUTHORIZATION:** I hereby give my consent for the school and Physician named above to exchange information concerning my child.

**PARENT'S SIGNATURE**

**DATE**

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> ADHD            | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Emotional Disorder    | <input type="checkbox"/> Heart Problem        | <input type="checkbox"/> Scoliosis         |
| <input type="checkbox"/> Allergy/Sinus   | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Epi-Pen injection     | <input type="checkbox"/> Hernia               | <input type="checkbox"/> Seizure Disorder  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Cystic Fibrosis     | <input type="checkbox"/> Eye surgery           | <input type="checkbox"/> Hypoglycemia         | <input type="checkbox"/> Skin Problem      |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Dental problems     | <input type="checkbox"/> Fainting spells       | <input type="checkbox"/> Muscular Weakness    | <input type="checkbox"/> Speech Problem    |
| <input type="checkbox"/> Bee Sting       | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Food allergies        | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Stomach Problem   |
| <input type="checkbox"/> Bladder /Kidney | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Frequent Constipation | <input type="checkbox"/> Nutritional Problems | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Blood Disorder  | <input type="checkbox"/> Ear infections      | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Pain in Joints       | <input type="checkbox"/> Tourette Syndrome |
| <input type="checkbox"/> Bone problems   | <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Hearing problem       | <input type="checkbox"/> Prosthetic Device    | <input type="checkbox"/> Vision / Glasses  |

Further explanation of above: \_\_\_\_\_

----- **PHYSICIAN'S EXAMINATION** -----

**IMMUNIZATION HISTORY: Insert dates in the appropriate boxes. Please indicate if immunizations are not complete.**

VACCINE	FIRST	SECOND	THIRD	FOURTH	FIFTH	SIXTH	Tdap/DTP after age 7
<b>IPV</b> (poliomyelitis)							
<b>DtaP/DPT/Tdap</b> (Diphtheria, Pertussis/Whooping Cough, & Tetanus) or <b>Td</b> (Tetanus & Diptheria)							
<b>MMR</b> (combination Measles, Mumps & Rubella)							
<b>HIB</b> (Haemophilus Influenza Type B)							
<b>Hepatitis B</b> (required for grades K & 7)							
<b>Hepatitis A</b> (recommended)							
<b>Varicella</b> <input type="checkbox"/> Had Disease							

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 PPD Date: \_\_\_\_\_ Chest X-ray: \_\_\_\_\_  
 Blood Pressure: \_\_\_\_\_  
 Hearing: \_\_\_\_\_  
 Vision R: \_\_\_\_\_ L: \_\_\_\_\_

SIGNIFICANT FINDINGS \_\_\_\_\_

RECOMMENDATIONS: (Special Education services are available to children with handicapping conditions or special needs) \_\_\_\_\_

Further evaluation for: \_\_\_\_\_

RECOMMENDATION FOR PHYSICAL ACTIVITY:  Unrestricted  Restricted \_\_\_\_\_  Athletic Participation

MEDICATION (Name and Dosage): \_\_\_\_\_

MEDICAL CARE: Is this child currently under your care? \_\_\_\_\_ How long? \_\_\_\_\_

Other medical specialists involved? \_\_\_\_\_

PHYSICIAN ADDRESS AND PHONE NUMBER: \_\_\_\_\_

I BELIEVE IT WOULD BE BENEFICIAL TO DISCUSS THIS FURTHER AND REQUEST THE SCHOOL NURSE TO CONTACT ME.

PHYSICIAN'S SIGNATURE

DATE

**IF YOUR CHILD DOES NOT HAVE HEALTH INSURANCE, HE/SHE MAY BE ELIGIBLE FOR INSURANCE UNDER COVERED CALIFORNIA FOR MORE INFORMATION, CALL 1-800-300-1506.**