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
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Scan/Email to:
recreation@lakewoodcityschools.org