

**GWINNETT COUNTY  
PUBLIC SCHOOLS  
MEDICAL REPORT FORM**

**Please return this form to:**  
**School Name: Oakland Meadow**  
**Address: 590 Old Snellville HWY**  
**Lawrenceville GA 30046 Fax: 770-513-6803**

Referring School: \_\_\_\_\_

Date Parent Received Form: \_\_\_/\_\_\_/\_\_\_

School Contact: \_\_\_\_\_

Date Parent Returned Form: \_\_\_/\_\_\_/\_\_\_

**I. STUDENT INFORMATION**

Student ID#: \_\_\_\_\_ Student Date of Birth: \_\_\_/\_\_\_/\_\_\_ Grade: \_\_\_\_\_

Student Last Name: \_\_\_\_\_ Student First Name: \_\_\_\_\_

Present or Last School Attended: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Residence Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**II. SCHOOL ATTENDANCE**

Medically able to participate in full academic day.

Medically able to participate in modified academic day. \_\_\_\_\_ hours/day Anticipated return date \_\_\_/\_\_\_/\_\_\_

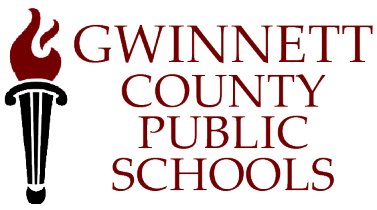
Unable to participate in school at the present time.

**III. MEDICAL INFORMATION**

DIAGNOSIS	PROGNOSIS	DATE OF ONSET	SEVERITY	FREQUENCY
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:

**IV. SURGICAL HISTORY**

DATE	TYPE	MODIFICATIONS REQUIRED DURING RECUPERATION
___/___/___		
___/___/___		
___/___/___		



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Student Last Name: \_\_\_\_\_ Student First Name: \_\_\_\_\_

**V. CURRENT MEDICATIONS**

MEDICATION NAME	PURPOSE	DOSAGE/ FREQUENCY	SIDE EFFECTS NOTED

**VI. MEDICAL CONDITION EFFECTS**

**Medical condition may adversely affect the student in the following areas:**

**Attendance:**

- Extended Absences
- Intermittent Absences
- Inability to attend a full academic schedule
- Other comments regarding attendance: \_\_\_\_\_

**Alertness:**

- Normal
- Decreased alertness exhibited by \_\_\_\_\_
- Other \_\_\_\_\_

**Other areas adversely affected by medical condition, please explain:**

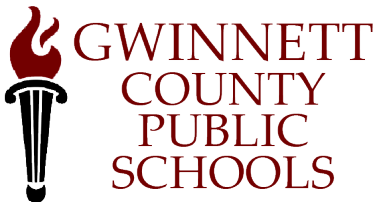
- Strength \_\_\_\_\_
- Vitality \_\_\_\_\_
- Daily Living Activities \_\_\_\_\_
- Academics \_\_\_\_\_
- Communication Abilities \_\_\_\_\_
- Other \_\_\_\_\_

**Physical Function/Ambulation:**

- Normal
- Limited, explain \_\_\_\_\_
- Physical ability to sit/move/manipulate materials \_\_\_\_\_

**Physical Education:**

- May participate in regular P.E. without restriction
- May participate in regular P.E. with the following modifications: \_\_\_\_\_
- May not participate in P.E.                      May Return to P.E. \_\_\_\_/\_\_\_\_/\_\_\_\_\_



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**VII. MEDICAL NEEDS/PRECAUTIONS**

**Medical needs/precautions during the school day (other than medication):**

<input type="checkbox"/> Medical needs:	<input type="checkbox"/> Medical precautions:
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**VIII. SYMPTOMS OF POTENTIAL MEDICAL PROBLEMS**

**Symptoms that may indicate potential medical problems and action required:**

SYMPTOM(S)	REQUIRED ACTION(S)

**Physician Signature:** \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Licensed Psychologist (if applicable): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Dept. Phone \_\_\_\_\_

Other Physicians: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

**Parent signature gives GCPS staff permission to speak with the physician or practitioner who signed this report about the student named above for the purpose of seeking clarification of diagnosis, prognosis, or any other comment by the physician or practitioner “related to the present diagnosis” to assist with educational programming.**

**Parent Signature:** \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_