



DEKALB COUNTY SCHOOL DISTRICT MEDICAL REPORT FORM

Please return to parent or school:

School Name: _____

Address: _____

Fax: _____

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
		_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ Acute, expected duration: _____
		_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ Acute, expected duration: _____
		_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ Acute, expected duration: _____
		_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ Acute, expected duration: _____

IV. SURGICAL HISTORY

DATE	TYPE	MODIFICATIONS REQUIRED DURING RECUPERATION



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V. CURRENT MEDICATIONS

MEDICATION NAME	PURPOSE	DOSAGE/ FREQUENCY	SIDE EFFECTS NOTED
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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):

☐ Medical needs:	☐ 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: _____ License #: _____

Address: _____ Dept. Phone _____

Other Physicians: _____

Parent/Guardian Name(s): _____

Parent signature gives DCSD 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: _____