LAKEWOOD CITY SCHOOLS

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 _____

_____

Allergies: □ NONE _____

Development:

Physical	□ normal	□ abnormal: _____
Behavioral	□ normal	□ abnormal: _____
Sensory	□ normal	□ abnormal: _____
Social	□ normal	□ abnormal: _____
Language	□ normal	□ abnormal: _____

II. IMMUNIZATIONS (fill in dates below or attach record):

	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE
DTaP/DTP					
Polio					
Hepatitis B					
Varicella					
MMR					
Tdap					
MCV4					

Other immunizations: _____

III. 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: _____

IV. 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: _____

V. PHYSICIAN INFORMATION (print or stamp):

Physician's Name: _____ Date: _____

Address: _____

Phone Number: _____

Fax Number: _____

Signature: _____