LAKEWOOD
CITY SCHOOLS

**PHYSICIAN'S MEDICAL REPORT TO SCHOOLS (K-12th)**

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 (attach record)**

**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: ___

Urinalysis: □ N/A □ normal □ abnormal: _____

TB test: □ N/A □ normal □ abnormal: _____

Lead: □ N/A □ normal □ abnormal: _____

**IV. RECOMMENDATIONS:**

Is this child able to participate fully in?

Classroom and academic activities □ YES □ NO

Physical education classes □ YES □ NO

Competitive athletics □ YES □ NO

Contact and collision sports □ YES □ NO

If limitations are advised, please specify:

_____

**V. PHYSICIAN INFORMATION (print or stamp):**

Physician's Name: _____ Date: _____

Phone Number: _____ Fax Number: _____

Signature: _____