LAKEWOOD CITY SCHOOLS

PHYSICIAN'S MEDICAL REPORT TO SCHOOLS

[To Be Completed By Student's Physician & Returned to School]

Student's Name:_____ DOB:_____

I. MEDICAL HISTORY:

Chronic Medical Conditions: ☐ Asthma ☐ Diabetes ☐ ADHD ☐ 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					
Polio					
HIB					
Hepatitis B					
Varicella					
MMR					
Tdap (booster)					

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: _____

Lakewood Community Recreation and Education Fax: 216-529-4464

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