



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):

	1 ST DOSE	2 ND DOSE	3 RD DOSE	4 TH DOSE	5 TH 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: _____