

# MEDICAL REPORT FOR STUDENTS (GRADES K-12) LANE COUNTY SCHOOLS

THIS SECTION TO BE FILLED IN BY PARENT BEFORE PHYSICAL EXAMINATION:

**PLEASE PRINT**

School to be attending \_\_\_\_\_ Grade \_\_\_\_\_

Students Name \_\_\_\_\_ Sex: M F Birthday \_\_\_\_\_  
 (Last) (First) (Month) (Day) (Year)

Address \_\_\_\_\_ Phone \_\_\_\_\_  
 (Street or Rural Route) (City /State/Zip)

Parent/Guardian \_\_\_\_\_ Physician \_\_\_\_\_

Check the following information about your child:

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| 1. Head/neck injuries                            | *Yes ___ No ___ Year ___ | 13. Kidney disease                        | *Yes ___ No ___ Year ___ |
| 2. Muscle bone or joint disease                  | *Yes ___ No ___ Year ___ | 14. Mononucleosis                         | *Yes ___ No ___ Year ___ |
| 3. Scoliosis                                     | *Yes ___ No ___ Year ___ | 15. Chickenpox                            | *Yes ___ No ___ Year ___ |
| 4. Loss or seriously impaired vision in one eye? | *Yes ___ No ___ Year ___ | 16. Insect/bee sting reaction             | *Yes ___ No ___ Year ___ |
|  | *Yes ___ No ___ Year ___ | 17. Asthma                                | *Yes ___ No ___ Year ___ |
| 5. Hearing Problem                               | *Yes ___ No ___ Year ___ | 18. Hay fever                             | *Yes ___ No ___ Year ___ |
| 6. Pneumonia                                     | *Yes ___ No ___ Year ___ | 19. Food allergy                          | *Yes ___ No ___ Year ___ |
| 7. Hernia  | *Yes ___ No ___ Year ___ | 20. Skin allergy                          | *Yes ___ No ___ Year ___ |
| 8. Diabetes                                      | *Yes ___ No ___ Year ___ | 21. Currently taking medications or shots | *Yes ___ No ___ Year ___ |
| 9. Fainting spells                               | *Yes ___ No ___ Year ___ | 22. Previous operations                   | *Yes ___ No ___ Year ___ |
| 10. Epilepsy/ seizures                           | *Yes ___ No ___ Year ___ | 23. Any other serious problems            | *Yes ___ No ___ Year ___ |
| 11. Streptococcus infection                      | *Yes ___ No ___ Year ___ |   |                          |
| 12. Rheumatic fever                              | *Yes ___ No ___ Year ___ |   |                          |

Comments on "Yes" \_\_\_\_\_

BEHAVIOR AND ANY PHYSICAL OR EMOTIONAL PROBLEMS: \_\_\_\_\_

## DOCTOR'S PHYSICAL EXAMINATION

Height _____	Vision with glasses/contacts <input type="checkbox"/>	<b>Immunization Summary</b>	Last Dose	
Weight _____	Vision without glasses <input type="checkbox"/>		Month/Year	Given Today
Blood Pressure _____	R 20/ _____ L 20/ _____	Diphtheria	_____	_____
		Whooping cough	_____	_____
		Tetanus	_____	_____
		Polio	_____	_____
		Sabin-oral	_____	_____
<b>Examination</b>	<b>Satisfactory</b>	<b>Unsatisfactory</b>	Salk	_____
Teeth	_____	_____	Measles (Vaccine)	_____
Hearing	_____	_____	Mumps (Vaccine)	_____
Cardiovascular	_____	_____	Rubella (Vaccine)	_____
Respiratory	_____	_____	<b>Chickenpox</b>	_____
Liver, spleen, kidney	_____	_____	<b>or Date of disease</b>	_____
hernia, genitals	_____	_____	Hep B	_____
Extremities	_____	_____	Hep A	_____
Orthopedic/posture	_____	_____	<b>TESTS</b>	<b>Given Today</b>
Neurological	_____	_____	Tuberculin	<b>Results</b>
Skin	_____	_____	Chest X-Ray	_____
			Indicated lab tests	_____
			Urine	_____
			Blood	_____

Significant illnesses or injuries \_\_\_\_\_

Diagnosis \_\_\_\_\_

I have on this date examined the above student and recommend him/her as being physically able to participate in regularly scheduled physical education classes and complete in the following supervised athletics: BASEBALL, BASKETBALL, CROSS COUNTRY, FIELD HOCKEY, FOOTBALL, GOLF, GYMNASTIC, SKIING, SOCCER, SOFTBALL, SWIMMING, TENNIS, TRACK, VOLLEYBALL, WRESTLING:

OTHER \_\_\_\_\_

\*This student may be permitted weight loss to make a lower weight class in WRESTLING: Yes \_\_\_\_\_ No \_\_\_\_\_.

If "Yes" may lose \_\_\_\_\_ pounds (Grades 6-12)

Date \_\_\_\_\_

(Signature of Examining Physician)