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

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

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 injures	*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	*Yes ____ No____ Year____	16. Insect/bee sting reaction	*Yes ____ No____ Year____
in one eye?	*Yes ____ No____ Year____	17. Asthma	*Yes ____ No____ Year____
		18. Hay fever	*Yes ____ No____ Year____
5. Hearing Problem	*Yes ____ No____ Year____	19. Food allergy	*Yes ____ No____ Year____
6. Pneumonia	*Yes ____ No____ Year____	20. Skin allergy	*Yes ____ No____ Year____
7. Hernia	*Yes ____ No____ Year____	21. Currently taking medications or	
8. Diabetes	*Yes ____ No____ Year____	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 ☐

Weight_____ Vision without glasses ☐

Blood Pressure_____ R 20/_____ L 20/_____

Examination	**Satisfactory**	**Unsatisfactory**
Teeth	_____	_____
Hearing	_____	_____
Cardiovascular	_____	_____
Respiratory	_____	_____
Liver, spleen, kidney hernia, genitals	_____	_____
Extremities	_____	_____
Orthopedic/posture	_____	_____
Neurological	_____	_____
Skin	_____	_____

Immunization Summary	Last Dose Month/Year	Given Today
Diphtheria	_____	_____
Whooping cough	_____	_____
Tetanus	_____	_____
Polio		
Sabin-oral	_____	_____
Salk	_____	_____
Measles (Vaccine)	_____	_____
Mumps (Vaccine)	_____	_____
Rubella (Vaccine)	_____	_____
Chickenpox	_____	
or Date of disease	_____	
Hep B	_____	_____ _____
Hep A	_____	_____

TESTS	**Given Today**	**Results**
Tuberculin	_____	_____
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 COUNTY, 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)

NOTE – Physician is licensed by the Oregon State Board of Medical Examiners Health Services 2008 Form # 147