

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"/>	Immunization Summary	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	_____	_____
Examination	Satisfactory	Unsatisfactory	Salk	_____
Teeth	_____	_____	Measles (Vaccine)	_____
Hearing	_____	_____	Mumps (Vaccine)	_____
Cardiovascular	_____	_____	Rubella (Vaccine)	_____
Respiratory	_____	_____	Chickenpox	_____
Liver, spleen, kidney	_____	_____	or Date of disease	_____
hernia, genitals	_____	_____	Hep B	_____
Extremities	_____	_____	Hep A	_____
Orthopedic/posture	_____	_____	TESTS	Given Today
Neurological	_____	_____	Tuberculin	Results
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)