

# 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 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<br>in one eye? | *Yes ___ No ___ Year ___ | 16. Insect/bee sting reaction                | *Yes ___ No ___ Year ___ |
|   | *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<br>shots | *Yes ___ No ___ Year ___ |
| 8. Diabetes   | *Yes ___ No ___ Year ___ | 22. Previous operations                      | *Yes ___ No ___ Year ___ |
| 9. Fainting spells                                  | *Yes ___ No ___ Year ___ | 23. Any other serious problems               | *Yes ___ No ___ Year ___ |
| 10. Epilepsy/ seizures                              | *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 \_\_\_\_\_ **Immunization Summary** Last Dose  
Month/Year Given Today

Weight \_\_\_\_\_ Vision without glasses \_\_\_\_\_

Blood Pressure \_\_\_\_\_ R 20/\_\_\_\_\_ L 20/\_\_\_\_\_

Diphtheria \_\_\_\_\_  
Whooping cough \_\_\_\_\_  
Tetanus \_\_\_\_\_  
TDAP \_\_\_\_\_

**Examination** **Satisfactory** **Unsatisfactory** Polio IPV \_\_\_\_\_  
Teeth \_\_\_\_\_ Measles \_\_\_\_\_

Hearing \_\_\_\_\_ Mumps \_\_\_\_\_  
Cardiovascular \_\_\_\_\_ Rubella \_\_\_\_\_

Respiratory \_\_\_\_\_ Varicella \_\_\_\_\_  
Liver, spleen, kidney  
hernia, genitals \_\_\_\_\_ or Date of disease \_\_\_\_\_

Extremities \_\_\_\_\_ Hep B \_\_\_\_\_  
Orthopedic/posture \_\_\_\_\_ Hep A \_\_\_\_\_

Neurological \_\_\_\_\_ **TESTS** **Given Today** **Results**  
Skin \_\_\_\_\_ 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 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)