

MEDICAL REPORT FOR STUDENTS (GRADE K) 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 in one eye? | *Yes ___ No ___ Year ___ | 16. Insect/bee sting reaction | *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	_____	_____
		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 COUNTRY, FIELD HOCKEY, FOOTBALL, GOLF, GYMNASIIC, 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)