SAN LORENZO UNIFIED SCHOOL DISTRICT

MEDICAL REPORT

Name ______________________ Birthdate ____________ ☐ Male ☐ Female School ________________

Reason For Referral: Preschool Kindergarten First Grade High School Special Placement Athletics

For The Following Observations: ____

Referred by ________________ Title ______________________ Telephone ________________

HEALTH HISTORY TO BE COMPLETED BY PARENT

Currently under the care of ____
Doctor's Name

PARENT/GUARDIAN'S AUTHORIZATION: I hereby give my consent to the school named above to receive from or send to Dr. ______________________________ any information concerning my child.

Parent/Guardian's Signature ______________________________________ Date ________________

Health History
(check or give dates)

- ☐ Allergy/Asthma
- ☐ Allergy to Drugs
- ☐ Cerebral Palsy
- ☐ Defective Vision/Glasses
- ☐ Diabetes
- ☐ Dizziness or Blackouts
- ☐ Ear Trouble/Hearing Loss
- ☐ Frequent Headaches
- ☐ Frequent Leg or Joint Pain
- ☐ Frequent Nosebleeds
- ☐ Heart Disease
- ☐ Hospitalization
- ☐ Kidney Disease
- ☐ Seizure Disorder/Epilepsy
- ☐ Speech Difficulty
- ☐ Tuberculosis

Further Explanation of Above: ____

- - - - - - - - - - PHYSICIAN'S EXAMINATION - - - - - - - - - -

IMMUNIZATION HISTORY: Insert dates in the appropriate box. If immunizations are not complete, please indicate.

Vaccine	1st	2nd	3rd	4th	5th	6th
Poliomyelitis (TOPV)						
DPT, and/or DtaP/DT						
Hepatitis B						
MMR						
Hepatitis A						
Varicella						

Height __________ Weight __________ Hearing __________ Vision __________ Blood Pressure __________

Hematocrit or Hemoglobin __________ Urinalysis __________ Other ______________________

Tuberculin Test __________ Date __________ BCG Vaccine __________ Date __________

Chest Xray Result __________ Date __________

SIGNIFICANT FINDINGS: ____

RECOMMENDATIONS: (Special Education services are available to children with handicapping conditions or special needs) __________

____

Further Evaluation For: ____

RECOMMENDATION FOR PHYSICAL ACTIVITY: ☐ Unrestricted ☐ Restricted ______________ ☐ Athletic Participation

MEDICATION: Name and dosage ____

MEDICAL CARE: Is this child currently under your care: ______________________
Other medical specialist involved? ______________________

☐ IN MY OPINION, IT WOULD BE BENEFICIAL TO DISCUSS THIS FURTHER AND REQUEST THE SCHOOL NURSE TO CONTACT ME.

Stamped or printed name and address of physician below:

____
Physician's Signature Date

DISTRIBUTION: WHITE - District Health Office YELLOW - School PINK - Physician