MEDICAL REPORT FOR STUDENTS (GRADE K) 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____
2. Muscle bone or joint disease *Yes ____ No____ Year____
3. Scoliosis *Yes ____ No____ Year____
4. Loss or seriously impaired vision *Yes ____ No____ Year____
   in one eye? *Yes ____ No____ Year____
5. Hearing Problem *Yes ____ No____ Year____
6. Pneumonia *Yes ____ No____ Year____
7. Hernia *Yes ____ No____ Year____
8. Diabetes *Yes ____ No____ Year____
9. Fainting spells *Yes ____ No____ Year____
10. Epilepsy/ seizures *Yes ____ No____ Year____
11. Streptococcus infection *Yes ____ No____ Year____
12. Rheumatic fever *Yes ____ No____ Year____
13. Kidney disease *Yes ____ No____ Year____
14. Mononucleosis *Yes ____ No____ Year____
15. Chickenpox *Yes ____ No____ Year____
16. Insect/bee sting reaction *Yes ____ No____ Year____
17. Asthma *Yes ____ No____ Year____
18. Hay fever *Yes ____ No____ Year____
19. Food allergy *Yes ____ No____ Year____
20. Skin allergy *Yes ____ No____ Year____
21. Currently taking medications or shots *Yes ____ No____ Year____
22. Previous operations *Yes ____ No____ Year____
23. Any other serious problems *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