Fort Lee Public Schools

STUDENT MEDICAL REPORT

STUDENT NAME: _____ **DATE OF BIRTH:** _____ **GRADE:** _____

➢ MEDICAL HISTORY

Diagnosis ICD-10 code: _____

Age at Onset: _____ Significant History: _____

_____

Date of Injury/Illness: _____

Treatment: _____

_____

Current medication: _____

➢ PHYSICAL EDUCATION & ATHLETIC PROGRAM:

Is the student medically cleared to participate in the Physical Education / Athletic program? Yes ☐ No ☐

If yes, are there any limitations? Yes ☐ No ☐

List any limitations: _____

➢ COVID TESTING

Date of COVID-19 test performed: _____ Result (please circle): Positive or Negative

Type of COVID-19 test administered (circle)*: Rapid Antigen Test or Molecular (RT-PCR)

**** Please note if the Rapid Antigen Test is administered, a PCR test confirming a negative result is required to return to school.***

➢ MEDICAL CLEARANCE

Date student is medically cleared to return to school: _____

Is the medical condition COVID related: Yes ☐ No ☐

Follow-up Necessary: Yes ☐ No ☐; if yes, appointment date: _____

➢ HEALTH CARE PROVIDER CONTACT INFORMATION (Physician contact information)

Physician's Original Signature _____ Date: _____

Print Name _____

Physician's Stamp (To include address & phone number)

School Nurse Name
School Address, Fort Lee, NJ 07024 Office: #

Fax: #