

Fort Lee Public Schools



STUDENT MEDICAL REPORT

NAME: _____ DATE OF BIRTH: _____ GRADE: _____

DIAGNOSIS ICD-10 code: _____

Age at Onset: _____ Significant History: _____

DATE OF INJURY / ILLNESS: _____

TREATMENT: _____

Medication: _____

RECOMMENDATIONS FOR SCHOOL (early classroom dismissal, assistance with books, assistance in hallways between class, seating assignments, lunch schedule modification, etc.):

ORTHOPEDIC IMPAIRMENTS:

Is the student required to use a mobility aid, orthopedic brace/support, or other type of medical equipment during school hours? Please check. Yes No Type of mobility aid: _____

Type of orthopedic brace/support or other medical equipment: _____

How long will the student need to use the medical equipment? _____

Protective footwear: Is the student required to wear protective footwear during school hours? Yes No

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: _____

DATE TO RETURN TO THE PHYSICAL EDUCATION/ATHLETIC PROGRAM: _____

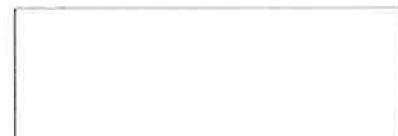
**If the student is unable to participate in the Physical Education/Athletic Program due to a medical condition or injury, a medical clearance note is required upon the date of return.*

DATE MEDICALLY CLEARED TO RETURN TO SCHOOL: _____

Physician Signature

Date

Physician Printed Name



PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)