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 OF 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.

LIST DATE STUDENT IS MEDICALLY CLEARED TO RETURN TO SCHOOL: _____

_____ _____
Physician Signature **Date**

_____
Physician Printed Name

PHYSICIAN STAMP
(TO INCLUDE ADDRESS & PHONE NUMBER)