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)

FLHS Health Office • 3000 Lemoine Avenue, Fort Lee, NJ 07024 • Office: (201) 585 – 4675 ext. 6502 • Fax: (844) 814 -7599

REV. 09/2022