Fort Lee Publ	ic Schools			
		BATTER		
	STUDENT M	IEDICAL I	REPORT	
NAME:	DAT	TE OF BIRTH: _		_ GRADE:
DIAGNOSIS ICD-10 code:				
Age at Onset:Sig	nificant History:			
DATE OF INJURY / ILLNESS:				
TREATMENT:				
Medication:				
RECOMMENDATIONS FOR S hallways between class, seating a				oks, assistance in
ORTHOPEDIC IMPAIRMENT	<u>`S:</u>			
Is the student required to use a mo school hours? Please check. Yes Type of orthopedic brace/support How long will the student need to	□ No □ Type of or other medical equipr use the medical equipn	mobility aid: ment: nent?		
Protective footwear: Is the student PHYSICAL EDUCATION & A			ng school hours?	
Is the student medically cleared to	participate in the Phys	ical Education/Ath	letic program? Y	es 🗆 No 🗆
If yes, are there any limitations?	? Yes 🗆 No 🗆	List any limitati	ons:	
DATE TO RETURN TO THE F	PHYSICAL EDUCAT	ION/ATHLETIC	PROGRAM:	
*If the student is unable to partic injury, a medical clearance note i			Program due to a	medical condition or
LIST DATE STUDENT IS M	IEDICALLY CLEA	RED TO RETU	RN TO SCHO	OL:
Physician Signature	Date			
Physician Printed Name				ICIAN STAMP DRESS & PHONE NUMBER)