DES MOINES INDEPENDENT COMMUNITY SCHOOL DISTRICT

STUDENT MEDICAL REPORT

Last Name _____ First Name _____ School _____ Grade _____

Birth Date _____ Sex _____ Phone _____

Parent or Guardian Signature _____ Address _____ Zip Code _____

ILLNESS/HISTORY		SCREENING DATA		
		TYPE	DATE	RESULT
___Allergy	___ Asthma/Reactive Airway			
___Chickenpox	___ Heart Defects/Surgery	Blood Lead		
___Diabetes	___Cancer	Dental		
___Hypertension	___Epilepsy/Seizures	Vision		
___Tuberculosis	___Neurological Impairment	Hearing		
___Rubella	___Overweight/Obesity	Developmental		
___Measles	___Mumps	Other _____		

Other Significant Illnesses, Chronic diseases, Injuries, Surgeries or Hospitalizations

Medications _____

May carry and self administer the following medication(s) -at school/school activities _____

PHYSICAL EXAMINATION **V= Normal or Negative**

Appearance _____	Ears _____	Hernia _____
Posture _____	Nose _____	Back _____
Nutrition _____	Throat _____	Extremities _____
Development _____	Lymph Nodes _____	Blood Pressure _____
Neurological _____	Thyroid _____	Urine Analysis _____
Speech Defect _____	Heart _____	Hemoglobin _____
Skin _____	Lungs _____	Height _____
Hair & Scalp _____	Abdomen _____	Weight _____
Eyes & Vision _____	Genitalia _____	Other _____

Remedial Defects/Developmental Delays _____

Physical Education Program: Full____ Limited ____ None ___ Reason for Limitation _____

School Accommodations ___ Seat close to instruction __ Liberal bathroom privileges ___ Glasses/Hearing Aids

Additional Comments or Recommendations _____

_____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

_____ **FULL & UNLIMITED PARTICIPATION**

_____ **LIMITED PARTICIPATION** - *May **NOT** participate in the following (checked):*

_____ Baseball _____ Basketball _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer
_____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling

_____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO** _____

Licensed Medical Professional's Name *(Printed)* _____ **Date** _____

Licensed Medical Professional's Signature _____ **Phone** _____