**Parent/Guardian Name:**

_____

First MI Last

**Phone:** (Home) _____-_____-_____

(Cell) _____-_____-_____

# Rahway Public Schools

Medical Report Form

**Provider Must Complete All Sections**

**Child's Name:**

_____

First MI Last

**Birth Date:** ____/____/____

**Gender:** Female □ Male □ Unclassified □

*I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.*

**Allergies:**

Medication: _____

Food: _____

Anaphylaxis: Yes □ (Complete Action Plan)

**Medical/ Surgical HX**:

_____

_____

_____

**Current Medication(s):**

_____

_____

_____

_____

***Medications administered at school must have doctors order.**

**Asthma**: Yes □ Complete Asthma Action Plan

**Seizures:** Yes □ Complete Seizure Action Plan

Results of Last Mantoux: Neg □ Pos □

Chest X-ray Results: _____

Treatment: _____

**Review of Systems:**

Temp: ___

Pulse: ___

Blood Pressure: ___/___

HEENT: _____

Neuro: _____

Mental Health Diagnosis □

_____

List mental health/Behavioral Concerns: _____

_____

_____

Heart: _____

Lungs: _____

Abdomen: _____

GI: _____

GU: _____

Musculoskeletal: _____

- Scoliosis: □

Limitations/special considerations/Equipment:

_____

_____

_____

**Specialists/Referred to:**

_____

**Nutrition:**

Height: _____Weight:_____

BMI: ____ BMI% _____

5% to 84% WNL □

< 5% or ≥ 85% Yes □

Nutritional Referral to:

_____

**Dietary Restrictions:**

_____

_____

**Special Diet:**

_____

_____

***Must have prescription if lunch provided by school***

**Vision**:

**Left** 20/___ **Right** 20/ ___

Passing: 20/40 < age 6

20/30 ≥ age 6

Wears Corrective Lenses □

Needs further evaluation □

**Referred to:**

_____

**Hearing:**

Passed: Right____ db. Left____ db.

Uses hearing aid/ assistive device □

Type: _____

Referred to:

_____

**Dental:** WNL □ Decay □

Needs Further Evaluation □

Emergency problem observed □

**Referred to:**

_____

**Must Have Provider Stamp**

☐ *I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child Care/school activities, including physical education and competitive contact sports, unless noted above.*

Provider Name (Print) _____ (Signature) _____ Date: ____/____/____