

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		
<input type="checkbox"/> Allergy	<input type="checkbox"/> Asthma/Reactive Airway	TYPE	DATE	RESULT
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Heart Defects/Surgery	Blood Lead		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	Dental		
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Epilepsy/Seizures	Vision		
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Neurological Impairment	Hearing		
<input type="checkbox"/> Rubella	<input type="checkbox"/> Overweight/Obesity	Developmental		
<input type="checkbox"/> Measles	<input type="checkbox"/> 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 _____