

**GWINNETT COUNTY
PUBLIC SCHOOLS
MEDICAL REPORT FORM**

Please return this form to: School Name: _____ Address: _____ _____ Fax: _____

Referring School: _____

Date Parent Received Form: ___/___/___

School Contact: _____

Date Parent Returned Form: ___/___/___

I. STUDENT INFORMATION

Student ID#: _____	Student Date of Birth: ___/___/___	Grade: _____
Student Last Name: _____	Student First Name: _____	
Present or Last School Attended: _____		
Parent/Guardian Name(s): _____		
Residence Address: _____	City: _____	Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____

II. SCHOOL ATTENDANCE

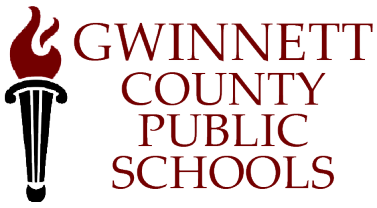
<input type="checkbox"/> Medically able to participate in full academic day.
<input type="checkbox"/> Medically able to participate in modified academic day. _____ hours/day Anticipated return date ___/___/___
<input type="checkbox"/> Unable to participate in school at the present time.

III. MEDICAL INFORMATION

DIAGNOSIS	PROGNOSIS	DATE OF ONSET	SEVERITY	FREQUENCY
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:
		___/___/___	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute, expected duration:

IV. SURGICAL HISTORY

DATE	TYPE	MODIFICATIONS REQUIRED DURING RECUPERATION
___/___/___		
___/___/___		
___/___/___		



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V. CURRENT MEDICATIONS

MEDICATION NAME	PURPOSE	DOSAGE/ FREQUENCY	SIDE EFFECTS NOTED

VI. MEDICAL CONDITION EFFECTS

Medical condition may adversely affect the student in the following areas:

Attendance:

- Extended Absences
- Intermittent Absences
- Inability to attend a full academic schedule
- Other comments regarding attendance: _____

Alertness:

- Normal
- Decreased alertness exhibited by _____
- Other _____

Other areas adversely affected by medical condition, please explain:

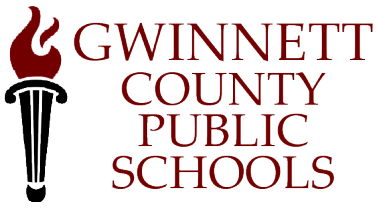
- Strength _____
- Vitality _____
- Daily Living Activities _____
- Academics _____
- Communication Abilities _____
- Other _____

Physical Function/Ambulation:

- Normal
- Limited, explain _____
- Physical ability to sit/move/manipulate materials _____

Physical Education:

- May participate in regular P.E. without restriction
- May participate in regular P.E. with the following modifications: _____
- May not participate in P.E. May Return to P.E. ____/____/_____



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VII. MEDICAL NEEDS/PRECAUTIONS

Medical needs/precautions during the school day (other than medication):

<input type="checkbox"/> Medical needs:	<input type="checkbox"/> Medical precautions:
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VIII. SYMPTOMS OF POTENTIAL MEDICAL PROBLEMS

Symptoms that may indicate potential medical problems and action required:

SYMPTOM(S)	REQUIRED ACTION(S)

Physician Signature: _____ **Date:** ____/____/____

Licensed Psychologist (if applicable): _____ **Date:** ____/____/____

Physician Name: _____

Address: _____ Dept. Phone _____

Other Physicians: _____

Parent/Guardian Name(s): _____

Parent signature gives GCPS staff permission to speak with the physician or practitioner who signed this report about the student named above for the purpose of seeking clarification of diagnosis, prognosis, or any other comment by the physician or practitioner “related to the present diagnosis” to assist with educational programming.

Parent Signature: _____ **Date:** ____/____/____