

ANAHEIM UNION HIGH SCHOOL DISTRICT
501 CRESCENT WAY, P.O. Box 3520
ANAHEIM, CALIFORNIA 92803
Special Youth Services
Physician's Medical Report

Name _____ School _____ Grade _____

Parent(s) _____ Date of Birth _____ Age ____ Male Female

Address _____

Phone (____) _____

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I hereby give my consent for the release and/or exchange of all confidential medical, psychological, educational and/or social information concerning the above named student.

Parent or Guardian Signature

Date

DIAGNOSIS (Include a brief description) _____

PROGNOSIS (Duration of Recovery) _____

TREATMENT: Is child currently taking any medications? Yes No (Please indicate drug name, dosage, and time of day to be taken) _____

How frequently do you see the student? _____

SPECIFIC RESTRICTIONS RELATIVE TO THE DISABILITY _____

DATE OF MOST RECENT VISIT? _____

HOW LONG HAS STUDENT BEEN UNDER YOUR CARE? _____

STUDENT IS PERMITTED TO HAVE MOVEMENT OF: (Indicate right side R or left side L)

Upper Body: Arm ____ Elbow ____ Wrist ____ Hand ____ Finger ____ Head and Neck ____ Trunk ____

Lower Body: Hip ____ Leg ____ Knee ____ Ankle ____ Feet ____ Toe ____

STUDENT MAY PARTICIPATE IN SPECIALLY DESIGNED MODIFIED PE ACTIVITIES SUCH AS:

- | | | | | |
|--|---|-----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Stretching | <input type="checkbox"/> Weight Lifting | <input type="checkbox"/> Walking | <input type="checkbox"/> Speed Walking | <input type="checkbox"/> Catching |
| <input type="checkbox"/> Running | <input type="checkbox"/> Jumping | <input type="checkbox"/> Twisting | <input type="checkbox"/> Throwing | |
| <input type="checkbox"/> Striking | <input type="checkbox"/> Bouncing | <input type="checkbox"/> Kicking | <input type="checkbox"/> Walk/Jogging 1 mile | |
| <input type="checkbox"/> Modified Games/Sports: Examples _____ | | | | |

MEDICAL REPORT FORM MUST BE UPDATED EVERY SEMESTER FOR TEMPORARY DISABILITIES

Print Name of Physician _____ Phone Number _____

Physician's Signature _____ Date _____

Address _____

License Number _____