

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 \_\_\_\_\_