GWINNETT COUNTY PUBLIC SCHOOLS

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

☐ Medically able to participate in full academic day.
☐ Medically able to participate in modified academic day. _____ hours/day Anticipated return date ___/___/_____
☐ Unable to participate in school at the present time.

III. MEDICAL INFORMATION

DIAGNOSIS	PROGNOSIS	DATE OF ONSET	SEVERITY	FREQUENCY
		___/___/_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ Acute, expected duration:
		___/___/_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ Acute, expected duration:
		___/___/_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ Acute, expected duration:
		___/___/_____	☐ Mild ☐ Moderate ☐ Severe	☐ Chronic ☐ 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: If yes, explain_____
☐ Intermittent Absences: If yes, explain_____
☐ 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):

☐ Medical needs:	☐ Medical precautions:

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:___/___/_____