Return Completed Form To:
Oxford Academy – Health Office
(714)220-3055 fax: (714)527-7128
email: gibb_r@auhsd.us

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:

❑ Stretching ❑ Weight Lifting ❑ Walking ❑ Speed Walking ❑ Catching
❑ Running ❑ Jumping ❑ Twisting ❑ Throwing
❑ Striking ❑ Bouncing ❑ Kicking ❑ Walk/Jogging 1 mile
❑ 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 _____