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 _____

DISTRIBUTION: White Copy - SYS; Yellow Copy - School Nurse; Pink Copy - Counselor; Goldenrod Copy - Parent
96600 (Form 559 - Revised 4/03)