ANAHEIM UNION HIGH SCHOOL DISTRICT
501 CRESCENT WAY, P.O. BOX 3520
ANAHEIM, CALIFORNIA 92803
Special Youth Services

Physician's Medical Report

Return completed form to:
Western High School- Health Office
Phone: 714-220-4048
Fax: 714-220-4027
Email: lowe r@auhsd.us

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)