Fort Lee Public Schools

STUDENT MEDICAL REPORT

STUDENT NAME: _____ **DATE OF BIRTH:** _____ **GRADE:** _____

MEDICAL HISTORY

Diagnosis ICD-10 code: _____

Age at Onset**:** _____Significant History**:** _____

_____

Date of Injury/Illness: _____

Treatment: _____

_____

Current medication: _____

PHYSICAL EDUCATION & ATHLETIC PROGRAM:

Is the student medically cleared to participate in the Physical Education / Athletic program? Yes □ No □
If yes, are there any limitations? Yes □ No □

List any limitations: _____

COVID TESTING

Date of COVID-19 test performed: _____ Result (please circle): Positive or Negative

Type of COVID-19 test administered (circle)*: Rapid Antigen Test or Molecular (RT-PCR)

**** Please note if the Rapid Antigen Test is administered, a PCR test confirming a negative result is required to return to school.***

MEDICAL CLEARANCE

Date student is medically cleared to return to school: _____

Is the medical condition COVID related: Yes □ No □

Follow-up Necessary: Yes □ No □; if yes, appointment date: _____

HEALTH CARE PROVIDER CONTACT INFORMATION (Physician contact information)

Physician's Original Signature _____ Date: _____

Print Name _____

School Nurse Name
School Address, Fort Lee, NJ 07024 Office: #

Physician's Stamp (To include address & phone number)

Fort Lee High School Health Office Nurse
3000 Lemoine Avenue, Fort Lee, NJ 07024 Office: (201) 585 – 4675 ext. 6502Fax: (844) 814 - 7599