Physician Medical Report and Parent / Guardian Release Form

Trumbull County Board of Developmental Disabilities – Fairhaven School Program
420 Lincoln Way, Niles, Ohio 44446
School - 330-652-5811 Fax – 330-652-5864

I. *Parent / Guardian Release of Medical Information*

Name of Individual (Please Print or Type) | Date of Birth | Program Area

Name of Physician | Physician Phone Number

Address of Physician | City | State | Zip Code

Date of last dental exam _____ Name / Phone No. of Dentist _____

I hereby give permission for release of medical and / or dental information to the TCBMR/DD Fairhaven Programs.

_____ ( ) _____ _____
Individual / Parent / Guardian Signature | Telephone Number | Date

II. *Physician's Report (please complete this ENTIRE form). Date of Examination:* _____

A. Medical Examination

Height _____
Weight _____
Head Circ. _____
Pulse _____
Blood Pres. _____
Temp. _____
Last Tetanus Injection _____
Hepatitis B Status (if known) _____

Medication? ☐ No ☐ Yes (list medication) Drug/Dose/Freq./Route/Times

_____
_____
_____
_____

Has Allergies? ☐ No ☐ Yes (list allergies)

_____

Dates of Hep B Vaccine Series _____

B. General Medical Examination (Indicate *ONLY* Abnormal finding and Explain)

☐ Head	☐ Nose / Throat / Mouth	☐ Lungs	☐ Genitalia	☐ Motor/Tone/Coordination
☐ Ears	☐ Glands	☐ Heart	☐ Spine	☐ Atypical Behavior
☐ Eyes	☐ Teeth / Gums	☐ Abdomen	☐ Cranial Nerves	☐ Atypical Behavior
☐ Neck	☐ Skin	☐ Extremities	☐ Reflexes	☐ Menstrual Hx

Comments:

_____
_____

C. Current Pertinent Laboratory Findings: Please attach copies: _____

D. Sensory Screening

Hearing: Normal _____ Suspect _____ Impaired _____ Deaf _____
Vision: Normal _____ Suspect _____ Impaired _____

E. Is there a contagious / communicable condition? ☐ No ☐ Yes If yes, reason: _____
If yes, anticipated duration: _____ Date of TB test & results: _____ - +

F. Immunizations administered today (if any) (please attach record): _____

G. Significant, relative past medical history: _____

_____

H. Current medical diagnosis: _____

I. Diet: ☐ Regular / General ☐ Other--list specific details / restrictions: _____

_____

J. Instruction and / or management (restrictions, precautions, ect.): _____

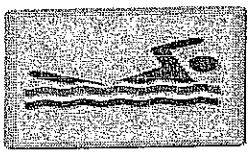
_____

K. Medically able to participate in gym, swimming and sports activities such as Ohio Special Olympics? ☐ Yes ☐ No

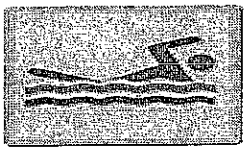
This certifies that information regarding the above named person is correct as of this date.

_____ _____
Physician's Signature and Phone Number | Date

Trumbull County Board of Developmental Disabilities - Fairhaven Programs



Fairhaven School
420 Lincoln Way
Niles, OH 44446-2836
330-652-5811 - Phone / 330-652-5864 - Fax



Because certain medical conditions demand additional attention, we are sending this form home to you. As stated in the Parent Information Handbook, for any students with a history of seizures or aspiration/swallowing concerns, Fairhaven policy regulations apply whereby parents and physicians must explicitly authorize swimming, and/or, exceptions for or excusal from swimming. If you have any questions, please call School Nurse 330-652-5811.

Parents / Guardians MUST.....

- Review conditions stated below and sign the form
- Take it to your doctor for signature
- Return it to the School

Thank You

The permission must be renewed ANNUALLY

Child's Name: _____

Fairhaven Swim Regulations for: Students with Known Seizure Disorders or Aspiration/Swallowing Concerns Parent/Guardian/Caregiver & Physician Permissions	Unless doctor writes specific other orders in this column or parents write comments, parent and doctor signatures below = *AUTHORIZATION*
I agree that the Fairhaven Swim Program Staff are responsible to determine the appropriate floatation device for my student. Options will include but not be limited to: life jacket, styrofoam belts, neck rings, water wings, arm floats, inner tubes, bar buoys, etc.	
I give my permission for this student to swim without a life jacket or floatation devices either for individual instruction, swim class, and/or competitive swimming.	
In cases of injury or extended illness, I know a signed permission from the doctor is required before return to the swim program is permitted.	

_____ _____

Signature of parent/guardian/caregiver Date

Any student that is tube-fed, requires Thick-It or is subject to aspiration must have permission from the doctor to swim.

If this is the case with your child, please have the doctor complete the information below and return to the school.

Your child will NOT be permitted to swim until such is received.

- ○ Yes, the child may participate in swim program
- ○ No, the child may NOT participate in swim program
- ○ The child may participate under the following conditions: _____

_____

_____ _____

Physician's Signature Date

Physician Name (please print):_____ Phone#: _____

Address of Physician_____