PHYSICIAN MEDICAL REPORT AND PARENT/GUARDIAN RELEASE FORM

Trumbull County Board of Developmental Disabilities – Fairhaven School
420 Lincoln Way, Niles, OH 44446
Phone: 330-652-5811 Fax – Nurse's Office: 330-574-4517

Parent/Guardian Release of Information: Program Area: _____

Name of Individual: _____ Date Of Birth: _____

Name of Physician: _____ Physician Phone: _____

Address of Physician: _____ City/State/Zip: _____

Date of last dental exam: _____ Name & Phone of Dentist: _____

I hereby give permission for release of medical and/or dental information to the TCBDD – Fairhaven School.

Parent/Guardian/Caregiver Signature: _____ Phone: _____ Date: _____

Physician's Report *(please complete this entire form)*. Date of Exam: _____

A. Medical Examination:

Height: _____

Weight: _____

Head Circ.: _____

Pulse: _____

Blood Pres: _____

Temp.: _____

Last Tetanus Injection: _____

Hepatitis B Status: _____

Medication? ❑ No ❑ Yes *(list medication):*

Drug	Dose	Frequency	Route	Times

Has Allergies: ❑ No ❑ Yes *(list allergies):*

_____

Dates of Hep B. Series: _____

B. General Medical Examination: *(indicate only abnormal findings and explain)***:**

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

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, etc.)*: _____

K. Medically able to participate in gym, swimming & 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 & Phone: _____ Date: _____

FAIRHAVEN SCHOOL SWIM PROGRAM PERMISSION FORM

Trumbull County Board of Developmental Disabilities - Fairhaven School Program
420 Lincoln Way, Niles, OH 44446
Phone: 330-652-5811 Fax – Nurse's Office: 330-574-4517

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 the School Nurse at 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.

This 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 flotation 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.	Comments:_____ _____ _____
I give my permission for this student to swim ***without a life jacket or flotation devices*** either for individual instruction, swim class, and/or competitive swimming.	Comments: _____ _____
In cases of injury or extended illness, I know a signed permission slip from the doctor is required before I return to the swim program is permitted.	Comments: _____ _____

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's Name *(please print)*: _____ Phone: _____

Address of Physician: _____