

MEDICAL DOCUMENTATION FORM for a HEALTH CONDITION

To be completed by Physician

Student Name: _____ Birth Date: _____

Title/Person requesting information: _____

Directions: Please identify existing health conditions that may affect the student's educational performance and progress.

Consent for Release of Information is attached Consent form is on file

Medical Diagnoses (please list all that apply):

Activity limitations or restrictions (e.g.: cannot participate in recess/physical education, needs assistance to move around building, no stairs, cannot carry books/backpack)

Implications for school attendance (e.g.: predicted absences, shortened school day, homebound)

Specialized health care procedures necessary during the school day (e.g.: blood sugar monitoring, medication administration)

Current medication(s): _____

Adverse effects on school performance from current medication(s):

Signature of Physician (required):

_____ Date: _____

PRINT Physician Name: _____

Clinic: _____

Address: _____

Phone: _____ Fax: _____