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):

_____

OVER →

Signature of Physician (required):

_____ Date: _____

PRINT Physician Name: _____

Clinic: _____

Address: _____

Phone: _____ Fax: _____