Health Condition Medical Documentation

Student Name: _____ DOB: _____

School: _____ Info requested by: _____

Your patient is in the process of being evaluated for additional education services or support. Your input will assist us in identifying health conditions that may affect his/her educational performance. A signed Release of Information is on file or is attached.

Current medical diagnosis that may affect the ability to be successful in school: (if ADHD is listed also complete the attached form)

Activity limitations or restrictions: (ex: requires mobility assistance, lifting restrictions, playground restrictions, etc)

Are absences from school expected, such as a shortened school day or predictable medical/treatment appointments?

Specialized health care procedures during the school day (ex: tube feeding, blood glucose monitoring, med administration)

Current medications:

Adverse effects from medicine that may impact school performance:

Provider Signature _____ Date _____

Printed Name _____

Clinic name and address _____ Phone Number _____

_____ Fax Number _____

Please return to Shakopee Public Schools Attn: Health Services Fax 952-496-5093