**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Date of exam: Click or tap here to enter text. Recommended follow-up exam date? Click or tap here to enter text.

Referral to another physician?  Yes  No

If yes, please provide the name and address of the physician: Click or tap here to enter text.

Please list the student’s diagnosis (i.e., physical or mental impairment)? Click or tap here to enter text.

Current medications:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Frequency |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

What effects, if any, will the medications have on the student’s learning (e.g., concentration, attention span, emotional side effects)? Click or tap here to enter text.

Please describe how the student’s medical diagnosis may interfere with the student’s ability to function at school:

Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Licensed Physician’s Signature Telephone Number

Click or tap here to enter text. Click or tap here to enter text.

Physician’s Printed/Typed Name Date

Click or tap here to enter text.

Address