MEDICAL REPORT

NAME OF CHILD: _____ STUDENT ID: _____
FIRST MIDDLE LAST

BIRTHDATE: _____ GRADE _____ AGE _____ DATE: _____
MONTH/DAY/YEAR MONTH/DAY/YEAR

PARENT(S):_____

PHONE: (WORK) _____ (HOME) _____ (OTHER) _____

HOME ADDRESS: _____ DISTRICT/AGENCY: _____
STREET ADDRESS/P.O. BOX CITY STATE ZIP

TO BE COMPLETED BY THE SCHOOL

Referral Date_____ School Contact Person _____ Phone _____

Medical concerns about this child are as follows:

At school

_____
_____
_____

At home

_____
_____
_____

NOTE: Consent for Release of Confidential Information with parent signature, is required.

TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR, DOCTOR OF OSTEOPATHY, OR ADVANCED REGISTERED NURSE PRACTITIONER (ARNP)

Information in the following areas would be helpful to the school and parents in planning for the child's educational needs. Please respond as appropriate, including any applicable medical diagnoses.

General health:

Motor functioning:

Neurological findings:

Allergies:

Medical Report

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Dietary considerations:

Vision (attach eye report):

Hearing:

Medications, including purpose:

Other pertinent information:

Please indicate ways in which any of the above may adversely affect behavior.

Is further medical evaluation or treatment planned for any specific area?

In what ways may your medical findings affect the school's educational or behavioral planning?

In what ways can school personnel facilitate ongoing communication with you?

If the child is involved in the **Systems of Care** program, please describe.

This information will be maintained in accordance with the Family Educational Rights and Privacy Act (34 CFR Part 99) and Individuals with Disabilities Education Act (IDEA).

Medical or epidemiological information or records which identify any person as having a communicable or venereal disease (such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus [also known as AIDS]) shall be strictly classified as confidential pursuant to Title 63 O.S. § 502.2.

Physician's or ARNP's name address, and telephone number (typed or stamped)	_____ **Physician's/ARNP's Signature** _____ **Date**