Health Care Provider's Certification of Medical Impairment

Date:

Student Name: Student Number:

Date of Birth: Grade: School:

As the parent or guardian of _____, I hereby consent to the release of information and follow-up communication in response to the questions presented below on this document.

_____ _____

Signature of Parent or Guardian Date

All of the following medical information is to be completed by a licensed physician.

Medical Diagnosis	Chronic or Acute	Permanent or Temporary	Severity (Mild, Moderate, Severe)	Date of Onset of Condition	Expected Duration of Condition

Medications

Name	Dosage	Time of Admin.	Notable Side Effects

Medical Implications for Instruction:

Please indicate the medical implications to consider for school planning:

Attendance	
Alertness (including environmental stimuli)	
Attention	
Strength	
Vitality	
Physical function/ ambulation	
Daily living activities	
Academic limitations	
School participation	
Communication skills	
Ability to move, sit, manipulate materials	

Student's Name:

Date of Birth:

1. **What <u>medically necessary</u> actions are required during the school day?**

2. **What symptoms should school personnel be aware of to indicate potential medical problems?**

3. **What, if any emergency procedures are you ordering for this student? Please specify these procedures sequentially below (and on attached pages, if necessary) in as much detail as possible.**

4. **Is this student able to participate in the regular physical education program without restrictions?**
   ☐ Yes ☐ No If no, please specify needed modifications and /or activities to be avoided.

5. **Has this student recently had surgery? ☐ Yes ☐ No If yes, what kind? _____**
   Date of surgery: _____ What modifications, if any, need to be made to accommodate the student's recuperation period?

6. **Is this student's health condition one that may cause (him/her) to be absent for intermittent periods of time during the school year? ☐ Yes ☐ No If yes, please explain.**

7. **Other Comments/Concerns**

Health Care Provider's Name (please print) _____

Signature of Health Care Provider: _____ License # _____

Address: _____

Telephone: _____ Fax: _____ Date: _____

Must be Georgia Board licensed physician, or in the case of ADHD, an evaluation by a licensed doctor of medicine or licensed clinical psychologist.

Revised 7/26/18