

Sample - Health and Education Plan - Physician Report

Student _____ Grade _____ DOB _____
 School _____ School Year _____

REFERRING STAFF:

#1 _____ Phone _____ Fax _____
 #2 _____ Phone _____ Fax _____
Print Staff Name Signature
 #3 _____ Phone _____ Fax _____
Print Staff Name Signature

PARENT: I CONSENT to communication and exchange of information between referring staff and doctors:

Dr. _____ Phone _____ Fax _____
 Dr. _____ Phone _____ Fax _____

Parent/Guardian Signature Home Phone Cell Phone Date

HEALTH CARE PROVIDER THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

Schools can provide the following and thus accommodate the needs of many pupils at school. Any other recommendations need to be specified. The School Team will determine if a 504 OR IEP is necessary. Please check appropriate boxes below.

*Instruction in the home is one of the most restrictive educational placements, must be viewed as a last resort, and used for the shortest time necessary. Careful completion of the following will assist in determining appropriate placement for the student**

DIAGNOSIS (include additional pages if necessary): _____

Student Should:

- Attend School
- Not Attend School Length of time: Weeks(#) _____ Months(#) _____ EXPECTED DATE OF RETURN: ____/____/____

If student is able to attend school, do they need:

- Modified/Reduced Schedule **Until:** _____/_____/_____
(DATE REQUIRED)
- Modified PE **Until:** _____/_____/_____
(DATE REQUIRED) No PE **Until:** _____/_____/_____
(DATE REQUIRED)

Other Recommendations: _____

Current Medications: _____

If medications need to be given during the school day, complete the Medication Required During School Day/Field Trips Form at _____ (school website)

PRIMARY CARE PROVIDER SIGNATURE PHONE FAX DATE

BEHAVIORAL HEALTH PROVIDER SIGNATURE PHONE FAX DATE

PLEASE RETURN TO THE REFERRING STAFF MEMBER, INDICATED AT THE TOP OF THIS PAGE

CLINIC STAMP - OR PRINT DOCTOR'S NAME HERE