DeKalb County School System
Health Care Provider's Certification of Medical Impairment

Student's Name: **Home Phone:**

Home Address: **City/State/Zip: ,** **DOB:** **Grade:**

School Name:

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 heightened alertness to environmental stimuli) _____

_____

•Attention _____

•Strength _____

•Vitality _____

•Physical function/ambulation _____

_____

•Daily living activities _____

_____

•Academic limitations _____

_____

•School participation _____

_____

•Communication abilities _____

_____

•Ability to move about, sit, manipulate materials _____

_____

•Other Comments / Concerns _____

_____

1. What **medically necessary** actions are required during the school day?

2. What symptoms should we 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? 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.

*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 February 11, 2011