Palo Alto
Unified School District

Health and Education Information

I. General Information

Student Name: (Last) _____ (First) _____ (MI) _____

School: _____ Grade: _____ Date of Birth: _____

*Number of Days Missed: Semester 1: _____ Semester 2: _____ Year to Date: _____

II. To be completed by Health Care Provider or Behavioral Health Provider:

Diagnoses/ Health Problems/Issues:

_____

_____

Current Medications (If medication is given during the school day, complete the Medication Authorization Form)

_____

_____

Please indicate whether you recommend any limitations on the student's participation in school activates:

☐ Student may participate in all school activities

☐ No Physical Education until _____/_____/_____

☐ Modified Physical Education until (describe below) _____/_____/_____

☐ Modified/ Reduced Schedule until (describe below) _____/_____/_____

☐ No outside activity if temperature is less than _____ and/or greater than _____

☐ Other restrictions (list below)

If you recommend a restriction(s) of activity(ies), please state the activity(ies) and for what time period.

Activity: _____ Until: _____/_____/_____

Activity: _____ Until: _____/_____/_____

Please provide any recommended adoptions/accommodations for school:

_____

_____

Provider Name (print): _____

Provider Signature: _____ Date: _____

Phone Number: _____

Fax: _____

Health Care Provider Seal

Wellness & Support Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-4208 | Fax 650-329-3832