Medical Information Questionnaire

Patient's Name:____________________________________ Date of Birth: ______________________________

Date of Most Recent Examination: __________________By Whom: ____

Does this patient possess a medical condition that requires a health plan on school campus? (i.e., heart condition, asthma, sickle cell anemia, epilepsy, diabetes, hemophilia, nephritis, leukemia, attention deficit disorder, etc.)

___ YES ___ NO

If yes, please provide the following information:

Diagnosis(es):

Diagnosis & Current ICD or DSM Code	Date of Initial Diagnosis	Prescribed Medication and Dosage

If there are restrictions, please list here:

____

Prescriber's Name (Printed): ____

Phone Number: __________________________________ Fax Number: ___________________________________

Prescriber's Signature: ____ Date: _________________________

Revised 08/2019