

MEDICAL RECOMMENDATION/ PHYSICIAN'S/ PROVIDER'S ORDER

Please type or print legibly

In order to better serve this child's educational needs, we would appreciate your cooperation in providing any precautions, special considerations, recent or upcoming surgical procedures, and/or medications that the student may need (activities, diet, equipment, etc.). Please complete this form and return as soon as possible.

Student: _____ Birthdate: _____ School: _____

1. The above named student is my patient and has been diagnosed with the following medical condition(s):

This patient has been under my care since _____

Diagnosis Code(s): _____

Therapy Evaluation(s)/Service(s) recommended:

☐ Occupational Therapy

☐ Physical Therapy

☐ Speech Therapy

☐ Annual Audiological (for those students with identified hearing conditions)

2. List special health care procedures, dietary restrictions, special diet, and/or activity restrictions, etc.:

3. If there are nutrition/dietary concerns, please list any allergies or food intolerances and substitutes including preparation: _____

4. Provide medical information regarding limitations due to strength, vitality or alertness: _____

5. List any medication administration(s)/treatment(s), dosage, and frequency currently prescribed: _____

Physician's/Provider's comments: _____

Please indicate your consent for evaluation(s)/service(s) by signing in the space below.

Physician's/Provider's Signature: _____

Date: _____ (This referral is valid one year from date of signature)

Physician's/Provider's Name (Printed or Typed): _____

Address: _____

Send To:

Bulloch County Schools
Department for Student Support Services

150 Williams Road

Statesboro, GA 30458

912/764-1636

912/764-2583 fax