FREDERICA ACADEMY PHYSICIAN'S STATEMENT OF HEALTH CONDITION

Patient's Name: ______________________________ Date of Birth: ______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I grant permission for my child's physician to release my child's medical information as requested below. I also grant permission for school personnel such as the nurse, counselor, or learning specialist to directly contact the physician completing this form to clarify information being provided below. I understand that information received will be treated confidentially and shared only with appropriate school personnel.

Parent or Guardian Signature (Required): ______________________________ Date: ______________

Physicians are asked to provide the following information to assist school teams in determining the impact of the child's medical condition on his or her education.

1. Diagnosis of current medical condition(s):

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2. Anticipated duration (acute versus chronic) of the medical condition(s):

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3. How does the diagnosis impact the child's performance in the academic setting?

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4. Medications currently prescribed to treat the medical condition(s):

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5. Treatment recommendations relevant to the student's educational performance including medications, dietary needs, activity restrictions, etc.:

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6. Will the diagnosed medical condition(s) and/or side effects of any prescribed medications potentially cause the student to be absent from school for more than ten days in a school year? If yes, please explain.

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PHYSICIAN INFORMATION:

Name: ______________________________ Phone: ______________

Address: ______________________________ Fax: ______________

Physician's Signature (Required): ______________________________ Date: ______________