Albuquerque Public Schools

School: _____
Address: _____

CHANGE IN MEDICAL STATUS

(*To be completed by physician/provider*)

Note to provider: *Current medical records, including diagnostic reports and/or hospital discharge summary are being requested. Please find the "Permission to Share Information" form attached and signed by the parent. Your cooperation helps us to provide necessary health care and support for this student during the school day.*

Please return to: _____at_____
(name) (school)
Address: _____ Fax: _____

Name of Student:	Student #:
Medicaid #:	

Medical Diagnosis/Problem List	ICD-10 code(s)
1._____	_____
2._____	_____
3._____	_____
4._____	_____

Synopsis statement (baseline status, etiologies, prognosis) _____
_____

Medications:	Prostheses/Appliances/Other Devices
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Will medication or any procedures (e.g. catheterizations, suctioning, oxygen, tube feeding, emergency care, etc.) be done routinely or on an as needed or emergency basis**?** yes no Explain**:** _____
_____
(If yes, please fill out the appropriate APS authorization/order form(s)

Special recommendations for management at school (prosthetic devices, special procedures as indicated above, restrictions, shortened school day, etc.)
_____
_____
_____
_____

Plan for Follow-up Medical Care: _____
_____
_____
_____

Provider's Signature: _____Date: _____

Provider's Name (printed): _____Phone: _____

Address: _____