Calallen Independent School District
Health Services Department

Calallen ISD Health Services Department

Special Health Condition Form

Student_____ Date_____

Campus_____ ID#_____

Calallen I.S.D. Health Services Department asks that the parent/guardian of students with special health conditions have their physician provide the school with additional information about the student so that we might be able to provide the best health care that we can while your child is at school.

Please have your physician complete those item's applicable, or if the condition no longer needs special attention at school please indicate so on this form.

Please return this form as soon as possible to your child's campus nurse, or ask your physician to fax it to the campus nurse.

Diagnosis _____

Past significant medical history _____
_____

Past surgical procedures _____

Procedures to be followed at school _____
_____

Medications to be given at school _____
_____

Specific s/s or precautions that may need to be monitored at school _____
_____
_____

Specific intervention to follow at school _____
_____

Specific restrictions and anticipated length of time for restrictions _____
_____

Estimated Due Date: _____

Signature of attending physician _____ Date_____

Physicians name _____ Phone_____

Signature of parent/guardian_____ Date _____