FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT
MEDICAL VERIFICATION FORM

Student: _____ Date: _____

Date of Birth: _____

Folsom Cordova Unified School District (FCUSD) is committed to provide education to support the academic performance of all students. The parents/guardians of the above named student have requested that FCUSD evaluate him/her for placement in a non-traditional setting because of a medical condition. We are requesting information in order to develop an appropriate educational program. The following information is required:

What is the medical diagnosis / ICD 10 code? _____

What is the prognosis? _____

What is the expected date of return to the student's regular education setting? _____

Does the medically disabling condition of this student expose the teacher to a contagious disease that can be transmitted through casual contact? Yes _____ No _____

What are the medical factors that the school team needs to consider to determine an appropriate educational program/setting for this student?

_____

_____

In case of an emotional, psychological or behavioral diagnosis, is this student receiving ongoing medical care?
Yes _____ No _____

I understand that placement of *this* student on Home Hospital Instruction is at the discretion of FCUSD.

_____
Signature of physician

_____
Name of physician

_____
Address of physician

_____
Phone number of physician

Please return to:
Director Health & Wellness
1965 Birkmont Drive, Rancho Cordova, CA 95742
(916) 294-9013 Fax (916) 294-9024

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