Medically Necessary Treatment in School Setting
Physician/Licensed Health Care Provider Statement

AS PARENT OR GUARDIAN OF: Student Name: _____ Birth Date: _____

PARENT / GUARDIAN:

I hereby give permission for the Physician/Licensed Health Care Provider(s) listed below to release written and verbal clarification regarding the information provided in this statement regarding the above-listed student's current medical and/or psychological conditions, diagnoses, and treatment to Adams 12 Five Star Schools (the District). Unless otherwise noted, this consent expires at the end of the current school year.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Dear Licensed Health Care Provider,

The parent/guardian of the student named above has indicated that the student presently requires medically necessary treatment in the school setting. By completing this form, you are affirming that the medically necessary treatment described on this form ***can only*** be provided during school hours and in the school setting. ***Medically necessary treatment cannot begin in the school setting until a physician or other qualified health care provider certifies that treatment can only be provided in the school setting and also specifies the nature, frequency, and length of time treatment is necessary.***

For Physician/Health Care Provider's Use Only:

1. Has the student (patient) been evaluated by the Physician/Health Care Provider in the past 30 days?

▢ Yes ▢ No

Date of last evaluation: _____

2. Does this student presently have an injury, illness, or other physical or mental condition that requires medically necessary treatment in the school setting during the school day?

▢ Yes ▢ No

If yes, please identify and provide details regarding the nature of the health concern and the reason why treatment within the school setting and during the school day is required:

_____

_____

3. Can the medically necessary treatment be provided outside of the school setting?

▢ Yes ▢ No

If no, please describe the limitations on the student's ability to participate in these treatments outside of the school setting: _____

_____

4. Considering this student's health issue, please describe the following:

   a. What is the nature of the medically necessary treatment that must be provided in the school setting?

      _____

   b. With what frequency must treatment be provided (e.g., how many minutes per day, week, month, etc.)?

      _____

   c. What is the anticipated duration of each treatment session (e.g., how many minutes per day, week, month, etc.)?

      _____

   d. Where in the school setting are you requesting that the student receive treatment (e.g., is a private location required)?

      _____

   e. How long do you anticipate the student will require treatment in the school setting (e.g., for x-number of weeks, for a semester, etc.)?

      _____

5. Please provide any other pertinent medical information that the District should consider in determining and making a plan for the provision of medically necessary treatment in the school setting. (Please attach additional sheets as necessary.)

_____

_____

_____

Physician/Health Care Provider Signature: _____

Date:_____ Printed Provider Name:_____

License #: _____

Practice Name: _____

Address: _____ Phone: _____