

**FONTANA COMPREHENSIVE HEALTH
PHYSICIAN'S REPORT**

PHYSICIAN DIAGNOSIS AND RECOMMENDATIONS

This form is extremely important to the success of the student. Please complete fully.

Student's Name _____ Sex M _____ F _____ Date of Birth _____

Address: _____ Home Phone _____

Parent/Guardian _____ School _____

History: _____

Diagnosis: _____

This student has the following disabilities/Health Conditions.

	Chronic	Acute	Expected duration of condition
1. Cardiovascular	_____	_____	_____
2. Neurological	_____	_____	_____
4. Respiratory	_____	_____	_____
5. Orthopedic	_____	_____	_____
6. Glandular	_____	_____	_____
7. Viral/Bacterial	_____	_____	_____
8. Other	_____	_____	_____

Details of the above: (State #) _____

Specialized Health Care Needs: (Trachs, Cath, Etc.) _____

Describe medication regime: _____

State medical plan: _____

State school site or classroom restriction/limitations regarding physical condition: _____

Specify special exercises that may be provided in physical education: _____

Physician's Signature _____ NPI # _____ Date _____

Physician's Printed Name: _____

