



I. To be completed by staff:

Staff Name: _____ Phone: _____ Fax: _____
Student Name:(Last) _____ (First) _____ (MI) _____
School: _____ Grade: _____ Date of Birth: _____
*Number of Days Missed: Semester 1: _____ Semester 2: _____ Year to Date: _____

II. To be completed by Health Care Provider or Behavioral Health Provider:

Diagnoses/ Health Problems/Issues:

Current Medications (If medication is given during the school day, complete the Medication Authorization Form)

Please indicate whether you recommend any limitations on the student's participation in school activities:

- ☐ Student may participate in all school activities
- ☐ No Physical Education until ____/____/____
- ☐ Modified Physical Education until (describe below) ____/____/____
- ☐ Modified/ Reduced Schedule until (describe below) ____/____/____
- ☐ No outside activity if temperature is less than _____ and/or greater than _____
- ☐ Other restrictions (list below)

If you recommend a restriction(s) of activity(ies), please state the activity and for what time period.

Activity: _____ Until: ____/____/____

Activity: _____ Until: ____/____/____

Please provide any recommended adoptions/accommodations for school:

Provider Name (print): _____

Provider Signature: _____ Date: _____

Phone Number: _____

Fax: _____



Health Care Provider Seal