



SCHOOL BOARD OF PINELLAS COUNTY, FLORIDA
EXCEPTIONAL STUDENT EDUCATION
RELEASE OF EDUCATIONAL AND MEDICAL INFORMATION AND PHYSICIAN REPORT FORM

Student Name: _____ Date of Birth: _____

School Name: _____

Physician Name (printed): _____

Physician Contact Number: _____

Physician Address: _____

City: _____ State: _____ Zip Code: _____

I. Release of Educational and Medical Information:

I hereby give permission for educational and medical information to be shared between Pinellas County Schools and the physician named above.

Parent Name (Printed): _____

Parent Signature: _____

II. Physician's Report:

A. Date of most recent evaluation: _____

B. Date of the most recent Vision and Hearing Screening: _____

• Results Vision Screening: (L) - N _____. F _____. _____

☐ Pass ☐ Fail

(R) - N _____. F _____. _____

☐ Pass ☐ Fail

• Results Hearing Screening. at _____ db

☐ Pass ☐ Fail

• Referral has been made to specialist:

☐ Yes.

☐ No.

C. Current medical diagnosis/condition:



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D. Current medications:

E. Possible side effects of medications:

F. The student's medical condition diagnosis/condition may result in:

- ☐ Significant limits the student's ability to move about, sit or manipulate the materials required for learning.
- ☐ Affects ambulation, posture or body use necessary in school work.
- ☐ Reduced efficiency in school work because of temporary or chronic lack of strength, vitality or alertness.
- ☐ Has no implications to the educational environment.
- ☐ Other:

G. Additional medical information to be shared with school personnel:

H. Recommend school-based evaluation and treatment, as indicated for:

Physical Therapy:	☐	Yes	☐	No	☐	Unable to determine
Occupational Therapy:	☐	Yes	☐	No	☐	Unable to determine

*Pinellas County Schools will determine if the student requires educationally relevant Physical and/or Occupational Therapy.

Name and title of person completing form (print): _____

Physician's Signature: _____

Date of Signature: _____