Georgia Cyber Academy
1745 Phoenix Blvd. Suite 100
Atlanta, GA 30349
Fax: 14047959097
Email: 504@georgiacyber.org

Health Care Provider's Certification of Medical Documentation

Student Name:	Date of Birth:
Home Phone:	Grade:
Home Address:	

As the parent or guardian of _____,
(print student's name here)
I hereby consent to the release of the information provided below.

Parent Signature: _____

All of the following medical information is to be completed by a licensed physician.

Medical Diagnosis	Chronic or Acute	Permanent or Temporary	Severity (mild, moderate, severe)	Date of onset of condition	Expected duration of condition

Medication:

Name of Medication	Dosage	Time of Administration	Notable Side Effects

Health Care Provider's certification of medical impairment for: _____
(Student's Name)

Medical Implications for Online Instruction

Attendance (online at home):

Alertness:

Attention:

Strength:

Vitality:

Physical function/ambulation:

Daily living activities:

Academic limitations:

School participation:

Communication abilities:

Ability to move about, sit, manipulate materials:

What medically necessary actions are required during the school day?

What symptoms should we be aware of to indicate potential medical problems?

What, if any, emergency procedures are you ordering for this student? Please specify these procedures sequentially below in as much detail as possible. Attach a separate piece of paper if necessary.

Is this student able to participate in the regular (online) physical education program without restrictions? Yes or No
If no, please specify needed modifications and/or activities to be avoided.

Has the student recently had surgery? If yes, what kind?
Date of surgery?
What modifications, if any, need to be made to accommodate the student's recuperation period?

Is this student's health condition one that may cause him/her to be absent for intermittent periods of time during the school year? Yes or No
If yes, please explain?

Does the student's health condition require him/her to attend required therapy sessions on a regular basis? If so, what is the frequency?

Health Care Provider's Name	
Health Care Provider's Signature	
NPI License #	Phone Number:
Address:	
Fax Number:	Date: