



YES Home Office  
6201 Bonhomme, Suite 168N  
Houston, Texas 77036  
713-574-7600  
713-589-2502 Fax

## PHYSICIAN STATEMENT OF MEDICAL INFORMATION

**Note:** The Student health plan and medical condition must be documented by a physician licensed to practice in the United States.

|                        |                                     |
|------------------------|-------------------------------------|
| Student Name _____     | Parents Name _____                  |
| Address _____          | City _____ State _____ Zip _____    |
| Student SSN _____      | Student Date of Birth _____         |
| Telephone (    ) _____ | Home (    ) _____ Work (    ) _____ |

### To Be Completed By Licensed Treating Physician

|                                 |                                                      |
|---------------------------------|------------------------------------------------------|
| Date of Last Office Visit _____ | Is Student currently hospitalized _____ Yes _____ No |
| Projected Discharge Date _____  | If yes, date of hospitalization _____                |

3. Diagnosis \_\_\_\_\_ Date of Onset \_\_\_\_\_  
Surgery \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, Date \_\_\_\_\_ Describe \_\_\_\_\_  
Symptoms exhibited \_\_\_\_\_

- List current medications

|  |  |  |  |  |
|--|--|--|--|--|
|  |  |  |  |  |
|--|--|--|--|--|

- Status of condition: \_\_\_\_\_ acute \_\_\_\_\_ chronic \_\_\_\_\_ stable \_\_\_\_\_ other

Explain \_\_\_\_\_

- Is pupil contagious at this time? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, state risk factor to teacher \_\_\_\_\_

- Please state any precautions the teacher should take \_\_\_\_\_

### 2. Referral History Data

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Describe functional implications which prevent this student from attending school:

- \_\_\_\_\_ Difficulty negotiating stairs and/or distances required. \_\_\_\_\_ Easily fatigued; needs additional rest periods.  
\_\_\_\_\_ Difficulty maintaining alertness and/or strength. \_\_\_\_\_ Frequent appointments with doctor and /or  
outpatient therapy  
\_\_\_\_\_ Has altered or impaired ability in concentration, memory and/or attention.

|                                       |                                                  |
|---------------------------------------|--------------------------------------------------|
| Signature of Licensed Physician _____ | Name of Licensed Physician (Print or Type) _____ |
| Medical Specialty _____               | Address of Physician _____                       |
| Telephone Number _____                | Fax Number _____                                 |
| Date _____                            |                                                  |

