Rockdale County Public Schools
RCPS

D

Please return this form to:

Name: _____

School: _____

Fax: _____

HEALTH CARE PROVIDER'S CERTIFICATION OF MEDICAL IMPAIRMENT AND RELEASE OF INFORMATION

Student Name: _____

Birthdate: _____ Grade:_____

Home Address:_____

City/State/Zip _____

As the parent or guardian of the student listed above, I hereby consent to the release of information and follow-up communication in response to the questions presented below on this document.

Signature of Parent or Guardian:_____ **Date:**_____

The following is to be completed by a licensed physician.

Medical Diagnosis	Chronic or Acute?	Temporary or Permanent?	Severity: Mild, Moderate, or Severe	Date of onset of condition	Expected Duration of Condition

Medications

Name	Dosage	Time of Administration	Notable Side Effects

MEDICAL IMPLICATIONS FOR INSTRUCTION:

Please indicate how the medical condition might adversely affect the student's participation/performance in the following areas:

•Attendance_____

•Alertness (including heightened alertness to environmental stimuli) _____

•Attention_____

•Strength_____

•Vitality, Physical function, Ambulation_____

•Daily living activities_____

•Academic limitations_____

•School participation_____

•Communication abilities_____

•Ability to move about, sit, manipulate materials _____

•Other Comments/Concerns _____

1. What medically necessary actions are required during the school day?

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

3. What, if any, emergency procedures are you ordering for this student? Please specify these procedures sequentially below (and on attached pages, if necessary) in as much detail as possible.

4. Is this student able to participate in the regular physical education program without restrictions?
   __Yes __No
   If no, please specify needed modifications and/or activities to be avoided.

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

6. 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 __No
   If yes, please explain.

Health Care Provider's Name (please print) _____ Date: _____

Signature of Health Care Provider _____UPI License #_____

Address:_____

Telephone:_____ Fax:_____

Physician: Please fax this form to the person listed at the top of page 1.