Date Physician Report given to parent _____
REPORT MUST BE RETURNED IN 10 DAYS

PHYSICIAN' S REPORT ON HEALTH IMPAIRMENT or PHYSICALLY HANDICAPPED STUDENT

Student's Name_____ **School**_____ **Grade**___

Birthdate_____ **Parent/Guardian**_____

Phone _____ **Address**_____

Last date of school attendance _____ **This student has missed** _____**days this school year.**

PHYSICIAN'S REPORT (To be completed in full by attending physician)

Date of Medical Examination_____

I. Explanation of Health Impairment or Handicapping Condition:

_____

_____

II. Physical Condition is such that student can:

A. _____ Regularly attend school and participate in all school activities.

B. _____ Regularly attend school with LIMITATIONS/ ADJUSTMENTS in the school program. Please identify adjustments/considerations: (i.e. gym, recess, dietary, rest periods, mobility, special transportation)

C. _____ Not able to attend school from _____ **(Start date)** **to** _____ **(Date able to return to school)**
due to medical condition.

OTHER COMMENTS/RECOMMENDATIONS_____

Date report completed_____

_____ _____
Physician's Signature **Physician's Name Print or Type**

_____ _____
Physician's telephone number **Physician Address or Stamp**

Return form to: _____