HEALTH CENTERS IN SCHOOLS

MEDICAL HISTORY UPDATE FORM

To Be Completed By Doctor

(This information will be utilized by the School Nurse to provide health services to students)

Student's Name___________________________**D.O.B.**__________**SS#**___________________

School___________________**Teacher/Grade**______________**School Nurse**_______________

CURRENT DIAGNOSIS & MEDICAL STATUS (*additional information may be attached)*

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MEDICATIONS:____

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Recommendations For Student Integration Into The School Setting

*ActivityRestrictions/Limitations*____

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*Accommodations*____

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*Nutritional /Dietary*____

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*AdaptivePhysicalEducation*____

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*PhysicalTherapy*____

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*OccupationalTherapy*____

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*SpecialProcedures*____

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Return To Clinic____

Physician's Signature________________________________***Date***_____________________

Print Dr.'s Name Here_______________________________***Office#***__________________

Address____***Fax#***____________________