MEDICAL HISTORY FORM
ZACHARY COMMUNITY SCHOOLS

Medical information is needed for the following student in order to determine if there are health impairments sufficient to warrant special education services. This information will also be utilized by the school nurse to provide health services. This form is to be completed by the Doctor. Please check appropriate behaviors and provide a simple explanation when indicated.

Name: ____ DOB: __________________________

Name of Parent(s)/Guardian: ____

Current Diagnosis, Medical Status, and Current Medication: ____
____

Date Last Seen: _________________________________ Return **to Clinic Date:** __________________________________

Severity of Illness: ____ Mild ____ Moderate ____ Severe
Condition Causes:

- ☐ temporary or chronic lack of strength
- ☐ temporary or chronic lack of vitality
- ☐ temporary lack of alertness
- ☐ reduced efficiency in school work because of _______________________________

Student is substantially limited in the following major life activity/activities: ____ caring for one's self ____ seeing ____ working ____ hearing _____ walking _____ performing manual tasks _____ breathing _____ speaking _____ learning _____ other major life activity (describe): ______________________________

Recommendations For Student Integration Into The School Setting

Activity Restrictions/Limitations ____

Accommodations ____

Nutritional/Dietary ____

Special Procedures ____

Speech Therapy ____

Physical Therapy/ Occupational Therapy/ Adaptive Physical Education ____________________________________

Please check if you agree to your patient receiving OT/PT (will be considered orders for service for one year from date doctor signed)

- ☐ Occupational Therapy
- ☐ Physical Therapy

Physician's Signature: __________________________________ Date: ________________________________

Print Physician's Name: ____

Physician's Address: ____

Office #: ______________________________________ **Fax #**: _______________________________________