Suwannee County School District
Student Services Department

Physician's Report

Student's Name: _____ _____ _____ Student # _____
Last First M

DOB: _____ Grade: _____ School: _____ Date: _____

1. What is the student's medical diagnosis? (Please include a description of the impairment.)

A student is eligible for a special program for the physically impaired if the student has an impairment as listed below (**CHECK** appropriate description of impairment):

☐ Orthopedic Impairment means a severe skeletal, muscular, or neuromuscular impairment which adversely affects the child's educational performance, and includes impairments resulting from congenital anomaly, disease and other causes(e.g., cerebral palsy, amputations, and fractures or burns that cause contractures). The student is limited in ability to move about, sit or manipulate materials required for learning or affects ambulation, posture or body use necessary in school work.

☐ Other Health Impairment means having limited strength, vitality, or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephiritis, asthma, sickle cell anemia, etc. The student is limited in reduced efficiency in school work because of temporary or chronic lack of strength, vitality or alertness.

☐ Traumatic Brain Injury means an acquired injury to the brain caused by an external physical force resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects educational performance. It does not include congenital or degenerative brain injuries or those induced by birth trauma. This impairment results in the student demonstrating significant difficulty requiring an adaption to the school routine, environment, or curriculum.

2. List any medical implications for instruction.

3. What medications, if any, is the student taking?

4. Describe any emergency procedures appropriate for the student.

5. Date of last physical examination: _____

Physician's Information:

_____ _____
Name/Title(please print) *Phone Number*

_____
Address/City/State

_____ _____
Signature (M.D. or O.D. required) *Date*

Please return to:
Office of Student Services
Suwannee County School District
702 2nd St. NW
Live Oak, FL 32064
Fax: 386-208-8687

SCSB Form #5200-043

Approved 1/1995
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