MEDICAL INFORMATION/P.E. EXCUSE FORM

_____ _____

STUDENT NAME DOB

_____ _____ _____

SCHOOL GRADE DATE

TO BE COMPLETED BY CHILD'S HEALTH CARE PROVIDER

THE ABOVE NAMED CHILD **IS** **WAS** UNDER MY CARE FOR THE FOLLOWING DIAGNOSIS:

WHICH IS **___CHRONIC ___ ACUTE ___TEMPORARY** CHILD **MEDICALLY RELEASED** _____

DATE OF RELEASE

******** PLEASE EXPLAIN **SPECIAL PRECAUTIONS** **DIETS** **PROCEDURES** **RESTRICTIONS** BELOW:

******** PLEASE IDENTIFY POSSIBLE REACTIONS AND NECESSARY INTERVENTIONS FOR THE ABOVE:

IF ABOVE IS TEMPORARY, WHEN CHILD MAY RETURN TO **FULL UNRESTRICED ACTIVITY:**

_____

******** DOES CHILD HAVE ALLERGIES? IF SO, PLEASE IDENTIFY AND INSTRUCT AS TO NEEDED INTERVENTIONS:

******** ARE PRESCRIBED MEDICATIONS TAKEN AT HOME? ____DAILY? ____PRN? ____NO

MEDICATION: _____ MEDICATION: _____

DOSE/TIME: _____ DOSE/TIME: _____

SIDE EFFECTS: _____ SIDE EFFECTS: _____

****** ARE MEDICATIONS TO BE GIVEN AT SCHOOL ON A LONG TERM OR PRN BASIS? ____YES ____NO**
(IF YES, PLEASE COMPLETE THE ATTACHED "MEDICATION CONTINUANCE FORM")

******** PLEASE ADVISE US OF ANY OTHER PERTINENT INFORMATION REGARDING THIS CHILD:

I AM A MEMBER OF THE HEALING ARTS, LICENSED TO PRACTICE IN THE STATE OF TEXAS

_____

SIGNATURE OF HEALTH CARE PROVIDER ADDRESS TELE. DATE

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

THE ABOVE INFORMATION IS CONFIDENTIAL AND WILL BE KEPT IN YOUR CHILD'S RECORD AT THE NURSE'S OFFICE. SCHOOL PERSONNEL ARE INFORMED ON A "NEED TO KNOW" BASIS ONLY FOR YOUR CHILD'S SAFTEY AND WELL BEING. PLEASE COME BY THE NURSE'S OFFICE SHOULD YOU HAVE ANY QUESTIONS.

**I REQUEST THAT THE ABOVE ACTIVITIES, MEDICATIONS AND/OR PROCEDURES BE CARRIED OUT AS STATED.

***PIDO QUE LOS ACTIVIDADES, MEDICINAS O PROCEDIMIENTOS ARRIBA SE LLEVEN A CABO COMO ESTAN DECLARADOS.

SIGNATURE PARENT/GUARDIAN—FIRMA PADRE/GUARDIA PLEASE PRINT NAME/FAVOR IMPRENTE NOMBRE DATE/FECHA