

WEST BATON ROUGE PARISH SCHOOL BOARD

Physician's Information Form

STUDENT'S NAME _____ AGE _____ D.O.B. _____ SEX _____

SCHOOL _____ GRADE _____

PARENT'S NAME _____ PHONE _____

MEDICAL CERTIFICATION (To be completed by a licensed physician) _____

The undersigned certifies that the above named student is unable to attend school for the following reason (specific medical diagnosis).

Pregnancy: Expected delivery date: _____

Is student free from infectious or communicable diseases? YES NO

If no, state the nature of the infectious disease and what specific precautions must be carried out for the safety of teachers and other educational personnel. _____

Is student at increased risk of acquiring infection? YES NO

If yes, state what specific precautions must be carried out by the teacher and other educational personnel for the safety of the pupil. _____

EXPECTED LIMITATIONS OR MODIFICATIONS FOR INSTRUCTION _____

EXPECTED DURATION OF CONDITION WHICH PREVENTS SCHOOL ATTENDANCE

_____ WEEKS (2-12 weeks)

FOR SERVICES RELATED TO EMOTIONAL CONDITIONS:

Describe the treatment plan.

a. Specific diagnosed condition _____

b. Activities prescribed _____

c. Frequency of treatment activity _____

d. Expected duration of treatment _____

e. Plan of action for returning the student to the general educational environment _____

f. Other specific therapy (i.e., prescribed medications) _____

COMMENTS: _____

The undersigned certifies that the above named student is receiving a program of care and treatment as prescribed in the information stated above:

Name _____ Date _____

(Please type or print)

Address _____ Telephone _____

Signature _____