ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN'S REPORT on STUDENT with MAJOR HEALTH PROBLEM

Name_____ Age _____ Birthdate _____ ID#_____
Last First Middle

Home Address _____ Zip _____

Parents/Guardians _____ School _____

Dear Doctor:

For educational purposes, the **Chicago Public Schools** considers a major health problem to be any health condition that interferes with the student's ability to participate fully and independently in the educational program. Please provide information regarding this student. The information will be used to assess the student's health and nursing needs in the school setting, determine the least restrictive environment for the student and to identify additional related supportive services. Please return the completed form to the school nurse promptly.

School Nurse _____ Date_____

MEDICAL DIAGNOSIS _____

_____

_____

_____

HISTORY AND DETAILED DESCRIPTION OF HEALTH PROBLEMS (including results of special tests, x-rays, surgery, etc.)

_____

_____

_____

_____

TYPE OF MEDICAL TREATMENT STUDENT IS CURRENTLY RECEIVING (including medication)

_____

_____

_____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		
4.		

PHYSICIAN'S REPORT on STUDENT with MAJOR HEALTH PROBLEM

DO YOU ANTICIPATE THAT THIS STUDENT WILL NEED HOME TEACHING AT ANY TIME DURING THE SCHOOL YEAR? _____ No _____ Yes

If yes, please specify the condition(s) in which home teaching may be necessary (***NOTE:*** an additional form entitled "***Medical/Psychiatric Referral for Adjustment of Education Program***" is required)

_____

_____

_____

ADDITIONAL CONCERNS _____

_____

PHYSICAL ACTIVITY

	NONE or	**SPECIFY LIMITATION**
Distance Walking	_____	_____
Stairs	_____	_____
Swimming	_____	_____
Gym/Physical Activity	_____	_____

Special Diet? Please describe _____

Does the student require adaptive equipment?

Braces _____ Glasses_____Helmet _____ Splints _____ Wheelchair _____ Other _____

Special Care Instructions:

_____

_____

How often should this student have a medical check-up? _____

_____Next scheduled appointment_____
Date

Monitoring on the School Bus is required for this student to and from school by: (please select)

☐ School nurse or ☐ School Bus Aide/Para Professional

Physician's Name_____ **Hospital Affiliation** _____
(Please print or type)

Address _____ **Telephone #** _____ **Fax #**_____

Physician's Signature _____ **Date** _____