School Physician Communication Form

To complete this form: Fill it out electronically, print, and sign, **OR** print, fill it out manually and sign.

To be completed by SCHOOL

Student Name: (First, Last) _____

Date of Birth: _____ Phone Number:_____

School Name: _____

School Contact Name: _____ School Phone Number: _____

Assessments completed:

Assessment tool	Assessment Date	Summary	Examiner Name

Date developed: _____ Date of last parent consultation: _____

Reports are attached: **Yes** ☐ **No** ☐

Comments on parent consultation:

Comments:

Identified goals:

Goals:

Supports currently in place:_____ Date started:_____

As parent/legal guardian of _____I hereby consent to School District No. _____releasing confidential information to Dr. _____for the purpose of gathering information as part of a comprehensive medical assessment. I understand that the information gathered throughout this assessment process will not be released to any other person or organization without my written permission. I understand that I can cancel or change the above authorization in writing at any time.

_____	_____	_____
Parent/Guardian Name (print)	**Parent Guardian Signature**	**Date**
_____	_____	_____
Student Name (print)	**Student Signature**	**Date**

To be completed by PHYSICIAN

The information on this form will be used in confidence to assist with aligning supports and services to support the child's learning. This information will be released to other parties only with the express written request of the student or parent/guardian.

(Please select all that apply)

Based on Dr. _____`s medical diagnosis, describe their functioning in the following areas:

Physical Functioning (gross motor, fine motor, sensory) varies from the average child:

◯ **RESET** ◯ Mildly ◯ Moderately ◯ Severely ◯ N/A ◯ Comments (below)

Comments:

Communication (receptive, expressive, pragmatic, stereotypic) varies from the average child:

◯ **RESET** ◯ Mildly ◯ Moderately ◯ Severely ◯ N/A ◯ Comments (below)

Comments:

Social and Emotional Functioning (inattention, thought problems, compulsions, aggression, etc.) varies from the average child:

◯ **RESET** ◯ Mildly ◯ Moderately ◯ Severely ◯ N/A ◯ Comments (below)

Comments:

Academic/Intellectual Functioning (achievement, learning difficulties, independence in school work) varies from the average child:

◯ **RESET** ◯ Mildly ◯ Moderately ◯ Severely ◯ N/A ◯ Comments (below)

Comments:

Self Determination/Independence (nutrition, parent and sibling adjustment, safety, feeding, dressing, hygiene, decision making):

◯ **RESET** ◯ Mildly ◯ Moderately ◯ Severely ◯ N/A ◯ Comments (below)

Comments:

Description of the diagnosis (reference other assessments as necessary): (if a diagnosis is not available, please provide the circumstances around the lack of diagnosis below)

Diagnosis details:

Contact Physician

Please feel free to contact my office to arrange an appointment for a telephone conference: ◯ **Yes** ◯ **No** (please check one)

_____	_____	_____
Physician Name (print)	**Telephone**	**Date**

As parent/legal guardian of _____ I hereby consent to Dr. _____ releasing confidential information regarding _____'s functional ability and diagnosis to School District _____ for the purpose of assisting in program planning and instructional support. I understand that I can cancel or change the above authorization in writing at any time.

_____	_____	_____
Parent/Guardian Name (print)	**Parent Guardian Signature**	**Date**
_____	_____	_____
Physician Name (print)	**Physician Signature**	**Date**