

H. Serv. 124
CHICAGO PUBLIC SCHOOLS
PHYSICIAN'S REPORT ON CHILD WITH NEUROLOGICAL DISORDER

(Last Name)	(First)	(Middle)	(BD)	(ID Number)
Home Address		Zip Code	Other Town	
Father's Name		Mother's Name	Telephone	
School	Grade	Non-Attending		

Dear Doctor,

The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files. _____

School Nurse

History of present illness: *(onset, etiology, trend in severity since onset, past and present treatment given)*

Type of Seizure:
Partial:

-
- Simple Partial
-
-
- Complex Partial
-
-
- Partial 2° to generalized

Generalized:

-
- Non-Convulsive
-
-
- Absence
-
-
- Myoclonic

Convulsive

-
- Tonic-Clonic
-
-
- Atonic (Astatic)

 Other _____

Description of seizure activity, behavior and/or conditions that precipitate seizures _____

Post-ictal status _____

Frequency and/or pattern of seizure activity: _____

Significant neurological examination results and/or test results: _____

Personality and behavior deviations *(hyperactivity, impulsivity, withdrawal, etc):* _____

Protective equipment required: _____

Current Treatment _____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		

Physician's Name _____ **Hospital Affiliation** _____
(Please print or type)
Address _____ **Telephone #** _____ **Fax #** _____

Physician's Signature _____ **Date** _____