HEALTHY CPS
— OFFICE OF STUDENT HEALTH & WELLNESS —

PROVIDER'S REPORT ON STUDENT WITH A MAJOR HEALTH CONDITION

(LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) (SCHOOL)

For educational purposes, the Chicago Public Schools considers a major health condition 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/nursing needs in the school setting, determine the least restrictive setting and identify related supportive services. Please return this to the school nurse promptly.

MEDICAL DIAGNOSIS:

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

DO YOU ANTICIPATE 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 application “Medical Referral for Adjustment of Education Program” is required)

_____

_____

_____

ADDITIONAL CONCERNS: _____

_____

PHYSICAL ACTIVITY	NONE or	SPECIFY LIMITATION
• Distance Walking	_____	_____
• Stairs	_____	_____
• Swimming	_____	_____
• PE/Physical Activity	_____	_____

SPECIAL DIET? Please Describe:_____

_____

DOES THE STUDENT REQUIRE ADAPTIVE EQUIPMENT? Please mark all that apply.

Braces_____ Glasses_____ Helmet_____ Splints_____ Wheelchair_____ Other_____

Special Care Instructions:_____

_____

How often should this student have a medical checkup?_____

Date of next scheduled appointment: _____

Provider’s Name (print)_____ **Hospital Affiliation**_____

Address_____ **Telephone #**_____ **Fax #**_____

Provider’s Signature_____ **Date**_____