FONTANA SELPA
PHYSICIAN'S REPORT

This form is extremely important to the success of the student. Please complete fully.

Student's Name_____ Sex: __M __F Date of Birth_____
Address:_____Home Phone_____
Parent/Guardian_____School_____

PHYSICIAN'S DIAGNOSIS AND RECOMMENDATIONS

History:_____

Diagnosis:_____

This student has the following disabilities/Health Conditions.

		Chronic	Acute	Expected duration of condition
1.	Cardiovascular	_____	_____	_____
2.	Neurological	_____	_____	_____
4.	Respiratory	_____	_____	_____
5.	Orthopedic	_____	_____	_____
6.	Glandular	_____	_____	_____
7.	Viral/Bacterial	_____	_____	_____
8.	Other	_____	_____	_____

Details of the above: (State #) _____
_____
Specialized Health Care Needs: (Trachs, Cath, Etc.) _____

Describe medication regime: _____
_____
State medical plan:_____

State school site or classroom restriction/limitations in regard to physical condition: _____
_____
Specify special exercises that may be provided in physical education: _____
_____

Physician's Signature_____ Date_____

MD Office Stamp Required

H-49
7/2012