



School Phone:
School Fax: (912)

DOCTOR'S REPORT

Date Sent: _____	_____ (Name of Student)	_____ (Birthdate)
By: _____	IF AVAILABLE: _____ (ID Number Used) _____ (ID Number Used)	

SCHOOL & ADDRESS: ATTENTION: _____

_____ (Complete Address)

DOCTOR'S NAME & ADDRESS: _____ (Doctor's Name or Medical Facility)

_____ (Complete Address)

PARENT RELEASE: I hereby give my permission for the doctor's office to release the following information concerning my child to _____ School. This release expires on _____.

_____ (Parent/Guardian/Surrogate Parent Signature) _____ (Witness)

To be completed by Doctor's Office Personnel & signed by Doctor

1. Doctor's name (print):
2. Date of most recent evaluation:
3. Diagnosis/Prognosis:
4. Medications prescribed and dosages:
5. Special health care procedures, special diet, or activity restrictions:
6. Please provide additional information, which may be useful for school personnel. Attach pertinent records for clarification, if needed.

_____ (Signature of Licensed Medical Doctor or Licensed Psychologist)