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)

In case of emergency contact:

NAME:_____ TELEPHONE:_____

ADDRESS:_____ RELATIONSHIP TO STUDENT:_____

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## PROVIDER'S REPORT

LMP _____ EDC _____ Gravida _____ Para _____ Gestation _____ Mos/Wks _____

First Appointment Date _____ Frequency of Appointments _____

Is the student able to continue in a regular school program? _____ Yes _____ No

List Restrictions (if any) _____

| Can this student participate in: | YES | NO |
|---|---|---|
| • PE | _____ | _____ |
| • Swimming | _____ | _____ |
| • Driver's education (behind the wheel) | _____ | _____ |

List (if any) student's chronic health problems (asthma, anemia, sickle cell anemia, diabetes, etc): _____
_____

Is this student taking any medication besides routine vitamins? If yes, please list: _____
_____

Date student is expected to begin maternity leave: _____
Expected place of delivery: _____
Additional comments/concerns: _____

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

**Address**_____ **Telephone #**_____ **Fax #**_____

**Provider's Signature**_____ **Date**_____