MIAMI-DADE COUNTY PUBLIC SCHOOLS

PHYSICIAN´S STATEMENT

(formerly entitled Report of Medical Examination)

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The Miami-Dade County Public School district seeks information from you for the purpose of education planning. Please complete the form, sign, and return to the address above.

Completed by School:

Student Name ____________________________ Student ID Number ________________

School __________________________________ Date of Birth ______________________

Parent Name _____________________________ Parent Telephone __________________

Completed by Physician:

Nature and extent of physical/health/medical condition ________________________________

Date of onset ________________ Prognosis ______________________________________

Medication prescribed/Dosage ____

How does this condition impact the student? ______________________________________

Signature and Title of Examining Physician

Date of Examination

Physician's Name (Print or type)

Physician's Mailing Address/Telephone Number