Horse Creek Academy
MEDICAL REPORT

TO BE COMPLETED BY SCHOOL PERSONNEL:

Student Name: DOB: School:

We are seeking medical information about this student for the following reasons:

_____

_____

Requested by:_____ _____
Name and Title *Date*

CONSENT FOR RELEASE OF INFORMATION

Name of Physician_____City/State_____

I give consent for the information requested on this form, to be released by the physician named above, to Horse Creek Academy. I also give consent for the person making this request to contact the physician by phone if there are questions about the information contained on this form. I understand that my consent will expire one year from the date of my signature, or earlier if I request.

_____ _____ _____
Signature of Parent/Guardian *Printed Name* *Date*

TO THE PHYSICIAN: Please complete this form and return it to by mail or fax as soon as possible. This information will be maintained in strictest confidence. Horse Creek Academy abides by the limitations and regulations of the Family Educational Rights and Privacy Act (FERPA). If the above release form is not signed, please see attached.

1. What are the student's current diagnoses? _____

_____

2. What medical treatments are currently prescribed for this student?_____

_____

_____

3. Recommendations for school?

_____ _____ _____
Signature of Physician *Printed Name of Physician* *Date*

Return completed form to: Fax:_____ Mailing Address:_____