Clear Form

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

_____