OXFORD PUBLIC SCHOOLS
OXFORD, CONNECTICUT
HEALTH SERVICES

PHYSICIAN QUESTIONNAIRE FOR STUDENT MEDICAL INFORMATION

This section is to be completed by the school:

Name of the Student:_____ **Date of Birth:**_____

Current Grade:_____ **School:**_____

School Address:_____

Parent/Guardian Name:_____

School Nurse's Name:_____

Phone: _____ **Fax:**_____

Oxford High School – Health Services Confidential FAX number: 203-888-8013
Great Oak Middle School – Health Services Confidential FAX number: 203-888-7798
Oxford Center School – Health Services Confidential FAX number: 203-881-5212
Quaker Farms School – Health Services Confidential FAX number: 203-888-6813

TO THE PHYSICIAN: **Your patient, the student named above, is currently enrolled in the Oxford Public Schools. The school is requesting the following information so that it may identify the student's needs prior to planning appropriate educational accommodations or programs for the student. The information is sought to gather updated health and medical information concerning the student for the purposes of:**

- ☐ School Evaluation under Individual with Disabilities Educational Act (IDEA)
- ☐ School Evaluation under Section 504 of the Rehabilitation Act
- ☐ School Evaluation for homebound services

Attached is HIPPA compliant parent/guardian consent for two-way communication. The information provided will be maintained as a confidential record and shared only with those who have an educational need to know under Family Educational Rights and Privacy Act (FERPA).

The school may periodically ask for updated information to assure that the plans made by the school are appropriate. Thank you in advance for your assistance to the school team.

This form must be completed by the child's physician and faxed from the physician's office to the Health Services fax number above or mailed directly to the school nurse at the address above. The information below must be completed by the physician and may not be completed by the student or parent.

I. Current Medical Information:

A. Medical diagnosis_____

_____

B. Date of last physical exam by undersigned physician:_____

C. Initial onset of Illness:_____

D. Description of Symptoms:_____

_____

_____

E. Overview of treatment plan, including medications:_____

_____

_____

_____

F. Prognosis and expected duration of illness:_____

_____

G. Any other pertinent medical information:_____

_____

_____

II. Impact of Medical Condition on Student's Functioning

A. How does the student's medical condition affect his/her overall functioning (Please be specific)_____

_____

_____

B. Does the medical condition affect the student's ability to attend school daily? ☐ No ☐ Yes
If YES, please describe the effect on school attendance and describe reasonable expectations for the student's attendance_____

_____

_____

What is the anticipated duration of the effect on attendance?_____

C. Does the medical condition affect the student's participation in physical activity? (PE classes, recess)
☐ No ☐ Yes If YES, please describe the affect on physical activity and provide reasonable expectations for the student's participation in physical activities:_____

_____

_____

What is the anticipated duration of the effect of the medical condition on the student's participation in physical activity?_____

D. Does the student's medical condition require specific restrictions or concerns regarding diet? ☐ No ☐ Yes
If YES, please describe any restrictions or specific concerns regarding diet at school_____

_____

What is the anticipated duration of the effect of the medical condition on the student's diet at school?_____

E. Is there any other information that would be helpful for the school in indentifying the student's needs?_____

_____

_____

_____ _____ _____
Name of Physician (Please Print) Signature of Physician Date

_____ _____
Physician's phone number Physician's address