Sudbury Student Services Consortium
de services aux élèves de Sudbury

Medical Information Form – F-MO4-404

Parent/Guardian: I authorize the Health Professional involved with my child's treatment to provide to me and the Sudbury Student Services Consortium this form when completed, containing information about any medical limitations/restrictions.

Signature:	Date (day/month/year):	Initial Form ☐ Follow-up Form ☐

Patient Information:

Patient's Last Name:	Patient's First Name:	Date of Birth (day/month/year):	
Address (No., Street, Apt.):	**City:**	**Postal Code:**	**Telephone No:**

The following information should be completed by the Health Professional:

Date of examination (on which report is based): (day/month/year)	Nature of illness or disability:
Health Professional's Designation: Physician ____ Other _____ Please specify _____	**Limitations:**
If the student is unable to walk to school, is there any other means by which he can get to school?	

Please outline patient's current restrictions:

Based on the listed restrictions the:

☐ Patient is capable of walking to school and/or a bus stop with **no restrictions**.

☐ Patient is capable of walking to school and/or a bus stop **with restrictions**.

☐ Patient is physically unable to walk to school and/or a bus stop at this time.

Please indicate the Abilities or Restrictions that apply, including any additional details.

Walking:	*Standing:*	*Sitting:*	*Stair Climbing:*
☐Full abilities	☐Full abilities	☐Full abilities	☐Full abilities
☐Up to 10 minutes	☐Up to 15 minutes	☐Up to 30 minutes	☐Up to 5 steps
☐10-30 minutes	☐15-30 minutes	☐30 minutes – 1 hour	☐5-10 steps
☐Other (specify):	☐Other (specify):	☐over 1 hour	☐Other (specify):
		☐Other (specify):	

Speech: related only to traveling to school ☐Full abilities ☐Other (specify):	*Concentration: related only to traveling to school* ☐Full abilities ☐Limited - tasks will take longer ☐Limited - tasks should require minimal concentration ☐Other (specify):	*Judgment: related only to traveling to school* ☐Full abilities ☐Limited - decisions will take longer ☐Limited - tasks should not require decisions to be made ☐Other (specify):	Memory: related only to traveling to school ☐Full abilities ☐Limited - tasks will be forgotten and may take longer to recall ☐Limited - tasks and requirements should be written down ☐Other (specify):
☐ Environmental exposure to: (e.g. heat, cold, noise or scents)	☐ Sight (specify):	☐ Hearing (specify):	☐ Potential side effects from medication (please specify, do not include names of medications):

2. Duration:
a) What is the expected duration of limitations?

3. From the date of this assessment, the above will apply for approximately: _____

4. Date patient first saw you about this condition: _____

5. Is the patient under the continuing care of a medical doctor?

General Comments/Specific Limitations:

Health Professional's Name (Please print):		Health Professional's Signature:	
Address (No., Street, Apt.):		City:	Postal Code:
Date (day/month/year):	Phone:	Signature:	

Return completed form to the Sudbury Student Services Consortium.