Sudbury Student Services Consortium
de services aux élèves de Sudbury

# Medical Information Form

**Parent/Guardian:** I authorize the Health Professional involved with my or 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:<br>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*<br><br>☐Full abilities<br><br>☐Other (specify): | *Concentration: related only to traveling to school*<br><br>☐Full abilities<br><br>☐Limited - tasks will take longer<br><br>☐Limited - tasks should require minimal concentration<br><br>☐Other (specify): | *Judgment: related only to traveling to school*<br><br>☐Full abilities<br><br>☐Limited - decisions will take longer<br><br>☐Limited - tasks should not require decisions to be made<br><br>☐Other (specify): | Memory: related only to traveling to school<br><br>☐Full abilities<br><br>☐Limited - tasks will be forgotten and may take longer to recall<br><br>☐Limited - tasks and requirements should be written down<br><br>☐Other (specify): |
| ☐ Environmental sensitivities 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.