WOCCSE MEDICAL STATUS REPORT

School Completes: ☐ General Education ☐ Special Education Date Last Attended: _____

Student Name: _____ District/School: _____

DOB: _____ Grade: _____ Student ID #: _____ Home Language: _____

Physician Section Only: Educational teams consider medical information in determining alternative educational services for students who acquire a temporary disability due to a medical trauma/condition. Please complete the information below and return to parent or fax to:_____.
You may direct questions to:_____.

1. What is the student's temporary disability/diagnosis that precludes the student from attending a regular school day?
☐Major surgery ☐Cancer/chemotherapy ☐Traumatic injury ☐Orthopedic complications ☐Debilitating injury

Explain: _____

☐Other: _____

2. Is the student contagious? Yes/ No

3. Is the student unable to leave the home? Yes/ No

4A. Can the student participate at school with special accommodations?
(e.g.: reduced hours/modified schedule, periodic breaks) Yes/ No

PLEASE SPECIFY: _____

4B. If the student is unable to attend a full school day but can attend part of the day (modified schedule), how many hours would be possible and/or medically safe? _____Hours/Day

5. Date medically cleared to begin home instruction: _____ Anticipated date of return: _____

6. Physician's Name (Please print): _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Physician's Signature: Date:

Parental Authorization for Exchange of Information: In considering the information provided, the district may seek clarification or additional records from the student's medical doctor for the purpose of making educational decisions. I understand that an authorization for release and exchange of information is necessary for the district to obtain clarification regarding my child's medical status in order to make appropriate educational decisions. I authorize the medical doctor signing this Medical Status Report to release relevant medical information contained in the medical record of my child regarding his/her current medical status to the .

Signature of Parent/Guardian: Date:

District of Residence (DOR)/School Site Verification by Signature As Required:

Site Administrator: _____ Date: _____

District Nurse: _____ Date: _____

☐ **HHI RECOMMENDED** An adult will be present at all times during home instruction. If a parent is not present, the home instruction session will not be provided.	Parent Initial	☐ **HHI NOT RECOMMENDED**