Archdiocese of Miami
Physician's Statement

_____

_____

_____

_____ (school name) seeks information from you for the purpose of education planning. Please complete the form, sign, and return to the address above.

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

_____