REPORT OF STUDENT WITH PHYSICAL DISABILITY, ALLERGY AND/OR RESTRICTIONS

NAME OF STUDENT

_____ _____
Last, First, Middle **Date of Birth**

_____ _____
Address **Telephone Number**

Nature of Physical Disability, Allergy and/or Restrictions

_____

_____

_____

Reported By: _____
Parent/Guardian - Name/Signature/Date

Reported To: _____
School Official - Name/Signature/Date

Health Care Provider: _____
Name /Address/Telephone Number

Report by Health Care Provider: _____
Date Received (Attach Report)

If no medical documentation is provided at the time of this report, please provide parent/guardian with the Bureau of Nursing Release of Information Form.
Given to: _____
Parent/Guardian – Print Name and Date

The following individuals have been advised of the nature and extent of the student's physical disability, allergy and/or restrictions*:

***Administrator:** _____ _____
Print Name **Signature/Date**

***School Nurse:** _____ _____
Print Name **Signature/Date**

***Phys Ed Teacher:** _____ _____
Print Name **Signature/Date**

***Classroom Teacher:** _____ _____
Print Name **Signature/Date**

Food Service Manager: _____ _____
(if applicable) **Print Name** **Signature/Date**

All four signatures required.

Completed Form to Be Placed in Student's Educational Packet and Cumulative Health Record