BARTOW COUNTY SCHOOL SYSTEM
PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM
FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

South Central Middle School
224 Old Alabama Road
Emerson, GA 30137
Attention: Annette Lively, RN
Phone: 770-606-5865 Facsimile: 770-606-5168

I authorize the release of my child's medical records/information to the above.

_____ _____
Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
Medication Dosage Route How often?

2. _____ _____ _____ _____
Medication Dosage Route How often?

3. _____ _____ _____ _____
Medication Dosage Route How often?

4. _____ _____ _____ _____
Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____
Physician's Name **Address** **Phone #**

_____ _____
Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Adairsville Elementary School
118 Franklin Street
Adairsville, GA 30103
Attention: Carla Hardy, LPN
Phone: 770-606-5840 Facsimile: 770-606-5165

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Allatoona Elementary School
4150 New Hope Church Road
Acworth, GA 30102
Attention: School Nurse
Phone: 770-606-5843 Facsimile: 770-975-4173

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Clear Creek Elementary School
50 Pleasant Valley Road
Cartersville, GA 30121
Attention: Debra Fetherolf, LPN
Phone: 770-606-5886 Facsimile: 770-770-386-4450

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Cloverleaf Elementary School
291 Highway 20 Spur
Cartersville, GA 302121
Attention: Sherri Green, RN
Phone: 770-606-5847 Facsimile: 770-606-5176

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Emerson Elementary School
220 Old Alabama Road
Emerson, GA 30137
Attention: Amanda Lawson, RN
Phone: 770-606-5848 Facsimile: 770-606-5181

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Euharlee Elementary School
1058 Euharlee Road
Kingston, GA 30145
Attention: Darlene Brown, LPN
Phone: 770-606-5900 678-721-4266

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Hamilton Crossing Elementary School
116 Hamilton Crossing Road
Cartersville, GA 30120
Attention: Terresa Holden, LPN
Phone: 770-606-5849 Facsimile: 770-606-3852

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Kingston Elementary School
240 Hardin Bridge Road
Kingston, GA 30145
Attention: Jessica Agan, LPN
Phone: 770-606-5850 Facsimile: 770-336-5591

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Mission Road Elementary School
1100 Mission Road, SW
Cartersville, GA 30120
Attention: Susan Buckner, LPN
Phone: 770-606-5863 Facsimile: 770-606-3862

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Pine Log Elementary School
1095 Cass Pine Log Road
Rydal, GA 30171
Attention: Ashton Johnson, LPN
Phone: 770-606-5864 Facsimile: 678-721-1917

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Taylorsville Elementary School
1502 Old Alabama Road
Taylorsville, GA 30178
Attention: Cary Eldridge , RN
Phone: 770-606-5867 Facsimile: 770-606-2056

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

White Elementary School
505 Colonel Way
White, GA 30184
Attention: Stacey Cantrell, LPN
Phone: 770-606-5869 Facsimile: 770-606-5177

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

III. Medical Diagnosis: _____

IV. Medication(s) related to this diagnosis that may be required at school:

5. _____ _____ _____ _____
   Medication Dosage Route How often?

6. _____ _____ _____ _____
   Medication Dosage Route How often?

7. _____ _____ _____ _____
   Medication Dosage Route How often?

8. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Adairsville Middle School
485 Old Highway 41 NW
Adairsville, GA 30171
Attention: Susan Long, RN
Phone: 770-606-5842 Facsimile: 770-606-5179

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Cass Middle School
195 Fire Tower Road
Cartersville, GA 30120
Attention: Mary Ann Hardy, LPN
Phone: 770-606-5846 Facsimile: 770-606-3835

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

V. Medical Diagnosis: _____

VI. Medication(s) related to this diagnosis that may be required at school:

9. _____ _____ _____ _____
Medication Dosage Route How often?

10. _____ _____ _____ _____
Medication Dosage Route How often?

11. _____ _____ _____ _____
Medication Dosage Route How often?

12. _____ _____ _____ _____
Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Woodland Middle School
1061 Euharlee Road
Euharlee, GA 30145
Attention: Leigh Ann Dickson, RN, BSN
Phone: 770-606-5871 Facsimile: 770-606-2092

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Adairsville High School
519 Old Highway 41
Adairsville, GA 30103
Attention: Amber Stanfill, RN
Phone: 770-606-5841 Facsimile: 770-773-2722

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Cass High School
1000 Colonel Way NE
White, GA 30184
Attention: Marcella Wright, LPN
Phone: 770-606-5845 Facsimile: 770-606-5467

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION

BARTOW COUNTY SCHOOL SYSTEM

PHYSICIAN'S MEDICAL DIAGNOSIS/MEDICATION DOSAGE VERIFICATION FORM

FOR CONSIDERATION OF STUDENT'S MEDICAL CONDITION

Student's Name: _____ DOB: _____

The Bartow County School System has received information that your child has a medical condition. All information is considered confidential. Please have your child's physician complete this form and return it to the following:

Woodland High School
800 Old Alabama Road
Cartersville, GA 30210
Attention: Rebecca Beard-Arndt, Clinic Personnel
Phone: 770-606-5870 Facsimile: 770-606-2080

I authorize the release of my child's medical records/information to the above.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

I. Medical Diagnosis: _____

II. Medication(s) related to this diagnosis that may be required at school:

1. _____ _____ _____ _____
   Medication Dosage Route How often?

2. _____ _____ _____ _____
   Medication Dosage Route How often?

3. _____ _____ _____ _____
   Medication Dosage Route How often?

4. _____ _____ _____ _____
   Medication Dosage Route How often?

*Please attach any pertinent information/ school health care plan(s) relating to this medical condition.

_____ _____ _____

Physician's Name **Address** **Phone #**

_____ _____

Physician's Signature **Date**

Revised May 2012; BARTOW COUNTY BOARD OF EDUCATION