Medical/Behavioral Health Provider to School Personnel – Communication Form

Name/credentials of Provider completing form:	Agency/Practice Name:
Phone #:	
Fax #:	Physician:
Email:	
Best way to reach: ☐ Phone ☐ Fax ☐ Email	Today's Date:

Student Name:	DOB:	Grade:
Home School District:	Current Educational Placement, if known:	
Primary School Contact Name: (with whom information will be shared)	School Contact phone/fax/e-mail:	
*Parentally signed HIPAA form must be completed. Please attach.		
Relevant concern/diagnosis/condition(s):		
How long have you been treating the student for this condition?	Frequency of appointments?	
	Date of last office visit:	
Is student actively participating in treatment/therapy? ☐ No ☐ Yes Comment:		
Other known providers:		
How does this condition impair the student's ability to participate in classes in school?		
Share ideas that could be considered to support the student in school:		
Are there any school activities in which you feel the student should not participate? Reason?		
When would you anticipate improved function? Would the student still need special consideration?		
Parents' understanding and perception of the situation?		
Other pertinent information?		
Copy to: Student or Patient Medical File		