

Morrisonville Community Unit District No. 1

Wesley Wells, Superintendent
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Licensed Medical Examiner Information Form

Please return this form to the Morrisonville Community Unit School District Superintendent's office promptly, as services cannot be started until medical information is received.

Patient's Name

Date

Date of Birth

Age

Grade

Sex

School

Medically eligible and physically able to enroll in the following program (Check One):

_____ a. homebound instruction _____ b. hospital instruction

ATTENTION MEDICAL EXAMINER: This Medical Certification Report must estimate that the pupil will need the special service indicated above for a *minimum of two weeks*. Below, please understand that the terms *indefinite or undetermined* are not acceptable for estimating approximate length of time.

ESTIMATED LENGTH OF TIME PUPIL WILL NEED ABOVE MENTIONED SERVICES THIS SCHOOL YEAR (in weeks) _____.

DIAGNOSIS:

Please Check

Classification

Congenital

Acquired

Neurological

Neuro-muscular

Bone and Joint

Other Medical

DEFINITE DIAGNOSIS:

Any special recommendation to the assigned teacher concerning diet, rest, exercise, position (sitting, reclining), etc.

Medical Examiner's Signature

(Please Print, Stamp, or Type Name)