Independent School District #318 **820 NW 1st Ave** **Grand Rapids MN 55744-2687** **Tel: (218) 327-5705**	**MEDICAL DOCUMENTATION**

Student:_____ ID:_____ Date:_____

School:_____ Grade:_____ DOB:_____

To be completed by physician:
Medical diagnoses (please list all that apply):

Activity limitations or restrictions (physical education, field trips, recess):

Implications for school attendance (ex. projected absences, homebound):

Medication or specialized health care procedures that are necessary during the school day:

Medications that may adversely affect school performance:

_____ _____
Physician's Signature Date

_____
Printed Name