ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

H. Serv. 124 **CHICAGO PUBLIC SCHOOLS**

PHYSICIAN'S REPORT ON CHILD WITH NEUROLOGICAL DISORDER

____
(Last Name) (First) (Middle) (BD) (ID Number))

____
Home Address Zip Code Other Town

____
Father's Name Mother's Name Telephone

____
School Grade Non-Attending

Dear Doctor,

The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files. ________________________________
School Nurse

History of present illness: (*onset, etiology, trend in severity since onset, past and present treatment given*)
____
____

Type of Seizure:

Partial:
- ☐ Simple Partial
- ☐ Complex Partial
- ☐ Partial 2° to generalized

Generalized:

Non-Convulsive
- ☐ Absence
- ☐ Myoclonic

Convulsive
- ☐ Tonic-Clonic
- ☐ Atonic (Astatic)

☐Other ________________
____

Description of seizure activity, behavior and/or conditions that precipitate seizures _________________
____

Post-ictal status ____

Frequency and/or pattern of seizure activity: ____

Significant neurological examination results and/or test results: _______________________________
____

Personality and behavior deviations (*hyperactivity, impulsivity, withdrawal, etc*):_______________________
____

Protective equipment required: ____

Current Treatment____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		

Physician's Name _________________________________**Hospital Affiliation** ____________________
(Please print or type)

Address __________________________________**Telephone #** ________________**Fax #**_______________

Physician's Signature ___________________________________**Date** ______________________________