ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

H. Serv. 110B

Com. No. 307

MEDICAL REPORT

Date _____

_____

(LAST NAME) (FIRST) (MIDDLE) (BD) (ID #)

_____

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

_____

(PARENT'S/ GUARDIAN'S NAME) (TELEPHONE) (SCHOOL)

Diagnosis and Prognosis:

Recommendations:

Physician's Name_____ **Hospital Affiliation** _____

(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____ **Date** _____