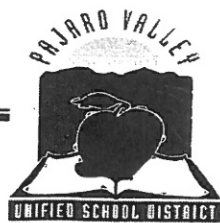


Pajaro Valley Unified School District



School Name & Address

Phone Number & Fax Number

H-9a, H-9a (S)

REQUEST FOR PHYSICIAN INFORMATION

Petición para información medical

STUDENT'S NAME/nombre: _____ DATE/Fecha: _____

BIRTHDATE/fecha de nacimiento: _____ GRADE/grado: _____

Reported health issue/problema _____

School Nurse/enfermera

Health Assistant/auxiliar de salud

Parent: I give permission for health care provider – school to exchange health information for school academic planning. Le doy permiso a la clinica o al medico para cambiar su información con la escuela.

Parent Signature/firma: _____ Date/fecha _____

We are concerned about this student's safety at school because of a reported health issue (see above). Please list any physical activities this student should not participate in during the school day.

This student is able to participate in all physical activities without restrictions during school.

Yes _____ No _____

Please list additional safety information or recommendations for this student:

Physician signature: _____ Printed Name _____ Date: _____

Address _____ Phone _____ FAX _____