MEDICAL ADVICE FORM - TO ADVISE THE SCHOOL IN PROVIDING APPROPRIATE EDUCATION SUPPORT

To be completed by the School/Academy:

Name of Child: ……..……Date of Birth: ……..…….....

Address: ……....

Home School / Academy: …….....Parent/Carer consent received YES / NO

To be completed by the child's consultant:

Name of health professional completing form: .....……...

Position held: ..... Hospital/place of work: .....

Contact number and email: ……..……..

Diagnosis/Formulation:

.....

Impact on the child's ability to attend school:

……

……..

Is the pupil medically fit enough to go to **MAINSTREAM** school? ***Full time / Part time / No*** (please circle as appropriate). **If No or part time please give reasons:**

…….....

If they are not fit for mainstream, Is the pupil medically fit enough to engage in some educational activities or formal learning in the home? ***Full time / Part time / No*** (please circle as appropriate). **If No or part time please give reasons:**

…….....

For how long might individual teaching or other support, be needed?

Up to 6 weeks / Up to 3 months / Up to 6 months / Other (please specify) .....

……

When might it be appropriate to begin engagement and re integration to school?

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……..

Date of next medical review: ……

Signature: ……..……Date: ……

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE WHEN COMPLETED TO:

If you require further information about this request please contact …….