

# Form 358.1 Registered Practitioner/Physician's Report: Student Safety or Medical Reasons

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## Lloydminster Catholic School Division

### Registered Practitioner/Physician's Report: Student Safety or Medical Reasons

Lloydminster Catholic School Division is committed to working with our students to ensure a safe and caring learning environment, if possible, and would appreciate any help you can provide in this regard.

We are seeking information that you may provide so that we can confidently plan a student's return to the school environment without posing a risk to their personal safety, the safety of others in the school, or a risk to property. Your feedback will also assist us in determining what accommodations might be necessary in order to address any medical restrictions, which may affect the student's ability to attend school and benefit from educational services.

Medical restrictions describe the student's limitations of skills and abilities that result from the student's disability, and which prevent the student from fully accessing educational services. Our efforts to accommodate a student are based on the specific restrictions that have been identified by the student's medical practitioner. Restrictions may be temporary or permanent. It is therefore important that we obtain medical information concerning the expected duration of the restriction(s).

Following recent incident(s) of concern, we are asking that a registered practitioner confirm in writing:

- the nature and extent of the student's restrictions, and
- the expected duration of each restriction.

### School Information

Summary of recent safety concerns

## Registered Practitioner/Physician's Report

Student Full Name: \_\_\_\_\_

Student Date of Birth: \_\_\_\_\_

Parent(s)/Guardian: \_\_\_\_\_

Attached is the Consent to Obtain/Release Information

1. The student last attended school on \_\_\_\_\_
2. The next date for clinical review is \_\_\_\_\_
3. Has the student, \_\_\_\_\_, been referred to a specialist who would have relevant information concerning the issues discussed in this report?

No

Yes

Dr. \_\_\_\_\_

Other \_\_\_\_\_

4. Does the student require medication to be administered while at school?

No

Yes

- a. Complete attached Form 316.2 – Letter to Doctor Regarding Health Services
- b. Or complete: Medical Authorization (To be completed by a doctor)

Type of Services Required:

\_\_\_\_\_

Frequency of Service: \_\_\_\_\_

Time(s) to be administered: \_\_\_\_\_

Anticipated duration of services or medical intervention:

Ongoing until further notice by a doctor  For the period

\_\_\_\_\_ to \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Doctor: \_\_\_\_\_

5. In your opinion is \_\_\_\_\_ fit for attendance at school?

Yes \_\_\_\_\_ No \_\_\_\_\_

If "No", in your opinion on what date can we expect \_\_\_\_\_

will be fit for in person attendance \_\_\_\_\_

If "No", are there any changes that could be made in the school environment to facilitate their safe return?

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6. Do you have a report or other information that would be important in addressing the diagnosis, needs or understandings you have of \_\_\_\_\_?

Yes \_\_\_\_\_ (Please attach or email the school principal)

No \_\_\_\_\_ (Please review the questions below)

- a. Please indicate any specific cautions, restrictions or services that should be in place as part of a return to school plan.

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- b. Please provide any specific information you can regarding specific stressors/situations, signs or symptoms, and precautions that would help to avert or reduce incidents.

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- c. Please provide any additional information that you feel would be pertinent and beneficial in order to facilitate \_\_\_'s school plan in a manner that will ensure a safe environment for \_\_\_\_\_ and other staff and students at school:

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7. A meeting can be set up with the school administration to review the case and facilitate understandings regarding \_\_\_\_\_ needs, an accommodation plan, and school supports. Please indicate if you are able to attend:

Yes \_\_\_\_\_

No \_\_\_\_\_

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Signature of Registered Practitioner/Medical Doctor

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Date