THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
MEDICALLY COMPLEX/FRAGILE STUDENT REVIEW COMMITTEE
LIST OF PHYSICIANS FORM

To: The Parent/Legal Guardian or Health Care Provider of:

_____ _____
(Student's Name) (Student's Date of Birth)

In order to develop an appropriate educational program for your child, we need to consider your child's medical needs. Please assist us in obtaining recent medical records by listing all Physicians/Home Health Agencies/Therapists which are currently providing or have recently provided medical care for your child.

(NOTE: In order for us to obtain the information from the physician we MUST HAVE THE COMPLETE NAME OF THE PHYSICIAN, COMPLETE ADDRESS AND PHONE NUMBER).

Physician's Name: Specialty_____

Dr.: _____ _____
Last, First Name Address

_____
City, State & Zip

_____ _____
Phone Number Fax Number

.....

Physician's Name: Specialty_____

Dr.: _____ _____
Last, First Name Address

_____
City, State & Zip

_____ _____
Phone Number Fax Number

.....

Physician's Name: Specialty_____

Dr.: _____ _____
Last, First Name Address

_____
City, State & Zip

_____ _____
Phone Number Fax Number

Phone Number Fax Number

(Over)

Physician's Name: Specialty _____

Dr.: _____ _____
Last, First Name Address

_____
City, State & Zip

_____ _____
Phone Number Fax Number

Physician's Name: Specialty _____

Dr.: _____ _____
Last, First Name Address

_____
City, State & Zip

_____ _____
Phone Number Fax Number

Physician's Name: Specialty _____

Dr.: _____ _____
Last, First Name Address

_____
City, State & Zip

_____ _____
Phone Number Fax Number

_____ _____ _____
(Completed By) Date Phone number

(To be completed by Area ESE office and parent/legal guardian).
Revised 07/01