KAMEHAMEHA SCHOOLS

REQUEST FOR MEDICAL EVALUATION

Date: ________________

From: ____________________________________ Phone:________________________
School Nurse / Athletic Trainer

Re: ____________________________________ DOB:______________ Grade:_____
Student Name

Please have a healthcare provider evaluate the student named above for the following medical reason(s) and complete the section below:

To be completed by the Healthcare Provider

Date Seen:_______________________**Diagnosis:** _________________________________

Medication(s): ____

Follow-up instructions: ____

Restrictions/limitations of activities if any (please be specific and include duration):

____ ____________________
Physician's Signature Date

____ ____________________
Physician's name & address Telephone

This form, or other document providing the same information, **MUST BE** returned and the student cleared by KS staff before the student can resume participation as applicable.

Rev. 10/2019