



Physician: Dr. ....

Tele #: .....

Name of student: .....

DOB..... Age: .....

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**Medical Condition:**

Asthma Diabetes Seizure Disorders Sickle Cell Hypertension Depression Other

If Other – Explain: .....  
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**Allergies:** Food Latex Medication Dust Other

If Other - Explain: .....  
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**Comments:**

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**Official stamp of Physician / Institution**