**_____ was seen in my office on _____**

(Student's name) (Date)

**Diagnosis: _____**

**Medication ordered:_____**

(specify name, dosage,

frequency, & how long _____

it should be given)

**Labwork/X-rays/test results:_____**

**_____**

**List restrictions, if indicated:_____**

**Return appointment, if required:_____**

Physician's signature_____Date_____

Physician's name_____

(please print)

Address_____

Phone number_____

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I give my permission to release any pertinent information regarding the diagnosis, medication, and/or treatment of my child, _____ to Glenwood Academy, 500 W. 187th Street, Glenwood, IL. 60425. (708) 756-6375.

Signature: _____

(Parent/Guardian)