Patient/Student Name: _____ **DOB:** _____**Grade:** ____ **Date:** _____
Health care provider: _____ **Email:** _____
Health care provider phone:_____ **Address:** _____
Parent name: _____ **Parent Phone:**_____ **Parent email**:_____

Virginia Chapter
Incorporated in Virginia
American Academy of Pediatrics

COMMUNICATION FROM PEDIATRICIAN TO EDUCATIONAL SYSTEM

Based upon the assessment of the primary care provider for the above student, the following areas have been identified as potentially impacting the school experience. We are reaching out to share information regarding symptoms and diagnoses relevant to this student's school functioning and to ask for school observations and input. The checked items below have been identified as relevant to school functioning:

Academic Functioning:

- □ ADHD
- □ Learning Disability
- □ Developmental Delay
- □ Sensory processing challenges
- □ Other: _____ _____

Social Determinants of Health:

- □ Food Insecurity
- □ Family Disruption
- □ Safety Concerns
- □ Housing Insecurity
- □ Other: _____ _____ _____ _____

Social and Emotional Functioning:

- □ Depression
- □ Anxiety
- □ Self-harm behavior
- □ OCD
- □ Bipolar
- □ Autism
- □ Other: _____ _____

Individual and Family Strengths:

- □ Engagement in care
- □ Determination
- □ Creativity
- □ Humor
- □ Resilience
- □ Emotional support
- □ Family stability
- □ Other: _____

COMMUNICATION FROM EDUCATIONAL SYSTEM TO PEDIATRICIAN

Please identify any areas in the school realm where the student faces challenges or could use additional support:

- □ Poor concentration/difficulties following directions
- □ Refuses to follow rules or argues with authority figures
- □ Gets angry, loses temper, gets into fights
- □ Seems sad, moody, or cries easily
- □ Worries excessively, seems fearful or anxious
- □ Does not enjoy interacting with peers
- □ Has been bullied
- □ Bullies others
- □ Skips meals
- □ Skips classes
- □ Excessive absences (Total days missed this school year: _____)
- □ Other: _____

Does the student receive any of the current supports or accommodations?

- □ 504 Plan
- □ Individualized Educational Program (IEP)
- □ Individualized Health Plan (IHP)
- □ Counseling
- □ Speech Therapy
- □ Occupational Therapy (OT)
- □ Physical Therapy (PT)
- □ Other: _____ _____

Additional recommendations, advice, or input:

_____
_____
_____
_____
_____

We appreciate your time and feedback in the coordinated care of this student.

School Nurse Name: _____ **Email address:** _____
School Counselor Name: _____ **Email address:** _____
Teacher Name: _____ **Email address:** _____
School: _____ **Phone:** _____**Fax:** _____

I, _____ (parent name), hereby give permission for the medical provider listed above and the school staff listed above to coordinate and share information with each other regarding my child's care.
Parent signature: _____ Date: _____
Health care provider signature: _____ Date:_____