Intermediate School District 917
Health Providers Information Sheet for Students with Multiple Health Problems

Student _____ **Birth Date** _____
Diagnosis _____ **School Year** _____

Specialist Names, if applicable ***Medical Specialty*** ***Phone/Fax Number***

(Family physician's contact information is already indicated on Student Emergency Contact form.)

1. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

2. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

3. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

4. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

5. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

6. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

7. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

8. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

9. _____ **Phone** (____) _____
   Clinic Name/Address: _____ **FAX** (____) _____

10. _____ **Phone** (____) _____
    Clinic Name/Address: _____ **FAX** (____) _____

For office use only:
LSN Signature _____ Date _____
Name of Staff Routing _____ Date _____
Please check off who was routed this form ___Student File _____ IEP Manager ___ 917 LSN ___Building Nurse