_____1st Request _____2nd Request _____3rd Request _____4th Request

Paradise Christian School
6184 West 21 Court, Hialeah, Florida 33016
Tel: 305-828-7477 Fax: 305-828-1950
Executive Director: Dr. Eileen Fluney

CONFIDENTIAL

Diagnostic Reporting Form

Date: _____ DOB: _____ Parent Name: _____

Child's
Last Name_____ **First Name:** _____ **Class:** _____

Attention Health Care Provider: Please complete in order that this child might qualify for special services provided by Head Start to accommodate his/her condition. Our referrals are to provide the highest quality services to our children, in order to accomplish this we need the team work of the families and physicians. We thank-you in advance for your prompt response and look forward to a partnership for "Healthy Children".

Reason for Referral: _____

Name of Health Care Provider: _____ Fax: _____

Phone: _____ ext. _____

Health Care Provider Please fill in below
and fax to : 305-828-1950 or email to: lmparadiz@gmail.com att: Health Services

Diagnosis: _____

Medications and dosage: ☐ Not applicable, if applicable complete: _____

Treatments: ☐Not applicable, if applicable complete: _____

Restrictions or precautions: ☐ Not applicable, if applicable complete: _____

Symptoms Child might experience that require attention: ☐ Not applicable, if applicable complete: _____

_____

Call parents when the following symptoms occur: ☐ Not applicable, if applicable complete: _____

_____

Health Care Provider: Signature: _____ **Date:** _____

Provider stamp: