| **Verification of medical condition** The Northern Health School works collaboratively with parents/caregivers, local schools and other relevant agencies to provide transition and teaching services for students who have high health needs. These needs will have been identified by a CAMHS team, or by a qualified medical practitioner specialising in the condition and will be involved in an active treatment programme. **Students remain enrolled in their school** as this service is not an alternative provider. If there is a reason why this is not possible, please state below. |
| --- |
| Student details |
| Student’s first name (LEGAL) | Student’s surname (LEGAL) |
| Student’s preferred first name | Student’s preferred surname |
| Date of birth |
| Parent/guardian name | Parent/guardian contact number |
| Parent / guardian consent |
| **In signing the Northern Health School enrolment form, the parent/caregiver (or student if 18 years old or over) consents to health information relevant to the educational programme being obtained and shared.** |
| **MEDICAL PRACTITIONER TO COMPLETE REASON FOR MEDICAL CONDITION / REFERRAL** |
| This patient has the following medical condition |
| In your judgement **how** does this condition prevent this student from attending school? |
| This patient (please tick as appropriate)☐ is on an active treatment programme for their medical condition☐ is on a health funded mental health programme☐ has been referred to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| In your opinion, when will this student be ready to return to school? Part time (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full time (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any other relevant information |
| Medical certificate valid from (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Note** *continued admission/enrolment at Northern Health School is subject to verification of the medical condition stated above.* *For most students, this verification expires after 15 weeks.*  |
| Name of medical practitioner(please print clearly) | Signature |
| Registration No  | Phone | Date |
| Name of medical practice |
| **Keyworker** (Please include phone and/or email) |

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