PARENT OR LEGAL GUARDIAN MEDICAL LIMITATIONS

This form must be completed by the parent or legal guardian's physician.

Date: ___________________________

Patient's Name: ____

Physician's Name: ____

Physician's Address: ____

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Physician's Telephone Number: ( ) _______________

Please describe any medical limitation or disability that the above named individual may have that would limit their ability to participate in the care of a patient with complex medical needs (e.g. lifting restrictions, developmental disorder, bed rest for pregnancy, etc.):

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If limitation/disability is temporary, please document the expected timeframe for resolution.

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Signature of Physician: ______________________________

National Provider Identifier: __________________________

Signature of Parent/Legal Guardian: ____
(By my signature, I am allowing release of this information to be used for the purpose of determining authorization for my child.)