KAMEHAMEHA SCHOOLS
Mālama Ola Health Services Department

REQUEST FOR MEDICAL EVALUATION

Date: ____________________

Student Name: ____ Student ID: __________________

School: ____________________________________ Grade: __________ DOB: ___________________

Ordering Provider: ______________________________ Referred To: ____________________________

Referral Reason: ____

Note: If student is being referred for a concussion evaluation, the following is required:

- If not concussion: Provide diagnosis, clearance to return to school, and activity restrictions if any.
- If concussion: Provide diagnosis, date cleared to return to school, date cleared for activity, any academic accommodations, and activity restrictions.
    - Note: Once cleared for activity by provider, a student who has sustained a concussion must complete a Return to Activity plan prior to returning to physical activity.

Pertinent Previous History: ____

To be completed by the Healthcare Provider

Provider, please complete all information below and put 'N/A' where indicated.

Diagnosis: ____

Restrictions/limitations of activities if any (please be specific and include duration: ________________

____

Date cleared for school: _______________ Date cleared for activity: _______________

Follow-up instructions/appointment date: ____

____

Provider Name: ____

Address: ____ Phone: ______________________

Signature: ____ Date: _______________________

Parent/guardian, please upload this completed document to the **Moʻomōʻali Olakino EHR Parent Portal** at https://ohana.ksbe.edu/ under the **Form Download/Upload Miscellaneous** section.