PLEASE RETURN BY FAX OR MAIL TO:

SLC HEALTH & WELLNESS CENTER
1 MEAD WAY BRONXVILLE, NY 10708
914-395-2350 (PHONE) 914-395-2640 (FAX)

STUDENT SECTION:

_____, authorize the completion and transmission of
STUDENT NAME (PLEASE PRINT)
the following clinical information to Sarah Lawrence College Health Services:

_____ _____
STUDENT SIGNATURE DATE

PROVIDER SECTION:

STUDENT NAME:_____ D.O.B.:_____/_____/_____

DIAGNOSIS: (If ADHD, please provide available testing data): _____

LENGTH OF CURRENT TREATMENT:_____

PRIOR TREATMENT HISTORY:

_____
_____

CLINICAL IMPRESSION:

_____
_____

CURRENT MEDICATION AND DOSAGES:

_____
_____

PREVIOUS MEDICATIONS AND DOSAGES:

_____
_____

RECOMMENDATIONS FOR MEDICATION TREATMENT:

_____
_____

ANY KNOWN CHEMICAL DEPENDENCY ISSUES:

_____
_____

SIGNATURE **LICENSE #** **DATE**

CLINICIAN NAME:
ADDRESS:
PHONE/FAX: