

Medical Information

Student _____ Date of Birth ___/___/___

School _____ Date ___/___/___

Parent(s)/Guardian _____ Phone _____

Address _____

Physician's Name _____ Phone _____ Fax _____

Dear Physician:

This student is having difficulties in school and

1. is in the process of evaluation for Special Education OR
2. is being reevaluated through Special Education due to a possible health impairment that significantly impacts school performance. The information below is a necessary part of the evaluation to help the team determine whether or not the student requires in-class interventions, Special Education, or other services to make adequate progress.

(Please respond to each item below.)

Diagnosis/Etiology: _____

Prognosis: _____

Is an evaluation available supporting the above diagnosis? Yes No

Please describe the impact of diagnosis on educational performance: _____

Treatment: _____

Medication: (+Dosage): _____

Type: _____

Major Learning Modality: (Check Applicable)

Visual Auditory Tactile Multisensory

Please make the most appropriate recommendation as to how this student can be function in an Education environment:

*Please provide psychological or medical reports that support the diagnosis(es), if available.

*Thank you for taking the time to provide this information. Please sign and date below.

Physician's Signature

Date