District Letter Head

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| Request for Health/Medical Information |

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| **Student Information**  |
| **Student Name:**  | **Date:**  |
| **Date of Birth:** | **District ID:** | **Grade:** |
| **Attending District:**  | **Attending School:**  |
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| The above named student has been referred for potential eligibility under Section 504 due to a physical or mental impairment. Please complete the following information and return to the person indicated. An authorization to use and disclose educational and protected health information is enclosed. Thank you for your information and timeliness. |
| 1. **Medical Diagnosis**
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| 1. Please list any current medical diagnoses of the student and provide the ICD10 diagnosis code. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| 1. Is the disability/impairment temporary? 🞎 Yes 🞎 No
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| 1. If temporary, what is the anticipated duration? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Which major life activities are affected? How?**
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|  | 🞎 Seeing | 🞎 Thinking | 🞎 Walking  | 🞎 Sleeping | 🞎 Communicating |
|  | 🞎 Hearing | 🞎 Concentrating | 🞎 Breathing | 🞎 Standing | 🞎 Interacting w/others |
|  | 🞎 Speaking | 🞎 Learning | 🞎 Other bodily functions | 🞎 Lifting | 🞎 Planning/Organization |
|  | 🞎 Reading | 🞎 Working | 🞎 Eating | 🞎 Bending | 🞎 Performing manual tasks |
|  | 🞎 Handwriting | 🞎 Caring for oneself  | 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Medical Treatment Plan (include medications and/or assistive devices):** (Please enclose)
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| 1. **Recommendations for accommodations or additional comments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Health Care Provider | Printed Name |  Date |
| **Please return to:** |
| Name:  | Title:  | Phone:  |
| Email: | Fax: |
| School/District:  |
| Address:  |

€ ***Authorization to Use and Disclose Educational and Protected Health Information is enclosed***

***Note****: This request for medical/health information will be used to assist in determining Section 504 eligibility.*

*The information you provide will be used with other evidence for the school 504 team to determine eligibility. If a student has a physical or mental impairment, the school 504 team will determine whether the impairment substantially limits one or more major life activities as required by Section 504 of the Rehabilitation Act of 1973.*

*A substantial limitation means the student is restricted as to the condition, manner or duration in performing the major life activity as compared to an average student. Your expertise as a medical provider is critical in understanding the impact of a disability on your patient.*