|  | **Medical Statement or Health Assessment Statement** |  |
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Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This child has been referred to determine special education eligibility. Oregon law requires that a medical statement or health assessment be obtained for some disabilities. **This information is urgently needed** to determine appropriate services for the child, and to comply with federal timelines for the special education evaluation. Please answer all questions in row(s) with checked boxes **and sign below**.

| **1. ▢** | Does the child have a vision problem?If yes, check each of the following that apply:▢ Child’s residual acuity is 20/70 or less in the better eye with correction.▢ Child’s visual field is restricted to 20 degrees or less in the better eye.▢ Child has an eye pathology or progressive eye disease that is expected to reduce residual acuity or visual field to one of the criteria listed above.▢ Assessment results are inconclusive and child demonstrates inadequate use of residual vision.---------------------------------------------------------------------------------------------------------Attach additional information about the vision problem(s), includingICD-10 Code(s):\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_ | ▢ Yes ▢ No |
| --- | --- | --- |
| **2. ▢** | Does the child have a hearing problem?If yes, complete the following:▢ Child has a sensory-neural hearing loss.▢ Child has a conductive hearing loss that: ▢ is ▢ is not treatable.▢ The use of amplification: ▢ is ▢ is not appropriate.---------------------------------------------------------------------------------------------------------Attach additional information about the hearing problem(s), includingICD-10 Code(s):\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_ | ▢ Yes ▢ No |
| **3. ▢** | Does the child have a voice disorder?If yes, attach additional information about the voice disorder, includingICD-10 Code(s):\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_ | ▢ Yes ▢ No |
| **4. ▢** | Does the child have relevant medical issues that contribute to speech/language problem(s)?If yes, attach a description of the medical issue(s) contributing to speech or language problem(s), including ICD-10 Code(s):\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_ | ▢ Yes ▢ No |
| **5. ▢** | Does the child have an impairment that is expected to last more than 60 calendar days?Mark all that apply:* Autism Spectrum Disorder ▢ Yes ▢ No
* Health Impairment ▢ Yes ▢ No
* Orthopedic Impairment ▢ Yes ▢ No
* Motor Impairment ▢ Yes ▢ No
* Traumatic Brain Injury caused by external force ▢ Yes ▢ No

If yes, please attach the required diagnosis or a description of the impairment(s) identified above, including ICD-10 Code(s):\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **6. ▢** | Has the child been diagnosed with other physical, medical, sensory or mental health condition(s) that may affect his/her educational performance?If yes, please attach the required diagnosis and a description of the diagnosis, including ICD-10 Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_ | ▢ Yes ▢ No |

Medical/Health Professional’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_