Siuslaw School District 97J

Request for Health/Medical Information

Student's Full Name:_____ Date:_____

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 below. A Release of Information Consent form is enclosed. Thank you for your information and timeliness.

1. Medical Diagnosis:

   a. Please list any current medical diagnoses of the student:

   _____

   _____

   _____

   b. Is the disability/impairment temporary? _____Yes _____No

   c. If temporary, what is the anticipated duration?_____

2. Which major life activities are affected? How?

☐ Seeing	☐ Thinking	☐ Walking
☐ Hearing	☐ Concentrating	☐ Breathing
☐ Speaking	☐ Learning	☐ Other bodily functions
	☐ Reading	☐ Other:

   Explain:

   _____

   _____

   _____

3. Medical Treatment Plan, including medications and/or assistive devices: (Please attach if necessary)

   _____

   _____

   _____

4. Recommendations for accommodations or additional comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider Printed Name Date

Please return to:

_____ _____

Name/Title School

_____ _____

Address Telephone Number

Original to District Student file
Cc: Student Cumulative/Building File, Parent