

SECTION 504 MEDICAL EVALUATION FORM

INSTRUCTIONS

1. Parent complete Section I of the Section 504 Medical Evaluation Form
2. Parent complete Authorization for Release of Confidential Information
3. Physician complete Section II of the Medical Evaluation Form
4. Physician must date and sign Section 504 Medical Evaluation Form
5. Return the completed Section 504 Medical Evaluation Form to the School Principal

SECTION 1 (to be completed by parent, guardian or person in parental relationship)

PLEASE PRINT CLEARLY

Name of Student **Name of Parent/Guardian or Person in Parental Relationship**

Address **Telephone Number**

City and Zip **School your child is Attending**

Grade **Date of Birth**

I, the undersigned, the parent, guardian or person in parental relationship of the aforementioned student on whose behalf this Section 504 Medical Evaluation Form is being filed, authorize _____ to provide medical information required to complete Section II of this
(Name of Physician)

Section 504 Medical Evaluation form.

Date

Signature of Parent, Guardian or Person in Parental Relationship

SECTION II (to be completed by the attending physician)

1. Are you the attending physician for the student listed above? Yes _____ No _____
2. Was the student referred to you by another physician? Yes _____ No _____
3. Please identify the student's medical diagnosis which may qualify as a physical or mental impairment under Section 504

4. Please explain *in detail* the specific impact (if any) the student's medical condition has on one or more of the following major life activities: Breathing, Learning, Working, Caring for One's Self, Seeing, Performing Manual Tasks, Hearing, Speaking, and Walking.

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5. How long have you attended the student named for the above medical condition? _____

6. Are mitigating measures or accommodations (i.e., medication, therapy) required to improve the student's medical condition? YES NO

If yes, please describe _____

7. What, in your professional judgment, is the prognosis concerning this medical condition?

8. Due to the student's medical condition, are there any restrictions in the following areas:

- | | | |
|--|-----|----|
| 1. Participation in physical education activities? | YES | NO |
| 2. Participation in extracurricular activities? | YES | NO |
| 3. Participation in an Intramural sports program? | YES | NO |
| 4. Participation in any athletic team? | YES | NO |

If yes, please list and explain any restriction(s) _____

9. Please attach any additional information which might be of assistance to the Section 504 Committee in reaching a determination of Section 504 eligibility.

Name of Physician _____

Address _____

Phone Number _____

Signature of Physician _____

Date: _____