Clear Form

CACHE COUNTY SCHOOL DISTRICT

SECTION 504 PHYSICIAN'S INFORMATION REPORT

Student: _____School: _____ Date:_____

Student ID: _____ Grade: _____ Date of Birth: _____

The above named student is being evaluated for protection under Section 504. Healthcare provider's reports, letters and diagnoses can be very helpful to the Section 504 Committee in determining eligibility and/or program planning. The parent/guardian of the above named student has provided consent for district/school personnel to release/request confidential records, which is attached. We appreciate your time answering the following questions in order to best meet the needs of the student.

Date of last physical exam: _____

Have you recommended a follow-up exam? Yes ☐ No ☐ Recommended time-frame _____

Please identify any medical problems/diagnoses for which the student is currently receiving medical care:

Date of onset: _____Severity of problem: ☐ Mild ☐ Moderate ☐ Severe

Please list all medications/treatments currently prescribed for the student:

Please describe possible side effects the student may experience from these medications:

Are there any restrictions from activities such as physical education or recess, if so please explain:

How will this impairment affect attendance?

Additional information/recommendations:

_____ _____ _____

Healthcare Provider's Name | Healthcare Provider's Signature | Date

Original: 504 Folder | Copy: Parent/Guardian | ADA Compliant 08/2018