SCHOOL DISTRICT NAME

SECTION 504 PHYSICIAN'S INFORMATION REPORT

Student: ______________________________ Campus: _____________ Date: ____________

Student ID: _________________________ Grade: ___ Date of Birth: ____________________

The above named student is being evaluated for protection under §504. Physician's reports, letters and diagnoses can be very helpful to the §504 Committee in determining eligibility and/or program planning. The parent/guardian of the above named student has provided consent for district 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 _____ If so, when? ____________

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 P.E. or recess, if so please explain:

How will this impairment affect attendance?

Additional information/recommendations:

__________________________ __________________________ ___________________
Physician's Name Physician's Signature Date

Original: 504 Folder Copy: Parent/Guardian