PHYSICIAN'S REPORT

For CHAPTER 15/Section 504 Evaluation and Requests for Accommodation

PHYSICIAN'S NAME:_____

OFFICE ADDRESS: _____

PHONE: _____

_____ presently enrolled in Otto-Eldred School District

(***Student name***) ***(School)***

The Otto-Eldred School District is exploring the whether the above-named child is a student with a physical or mental disability which substantially limits a major life activity and results in a need for accommodations in order for that child to participate in the school district's programs and activities. The following information will be helpful in making those determinations.

- How long have you treated the child?

  _____

- Diagnosis:

  _____

- Please list the health concern/illness/disability and described how it limits or impacts this child's life activities. "Life activities" can include seeing, hearing, walking, sleeping, working, eating, breathing, communicating, speaking, learning, functioning of major body functions, etc.

  _____

  _____

  _____

- Is the child on any medication? Please list. Does the child need to take those medications during school hours?

  _____

  _____

- Does the child have/need assistive devices (e.g. hearing aids, walker, wheelchair, etc.)?

  _____

  _____

- Will he/she need these at school?

  _____

- In your opinion, how severe are the child's needs at his/her worst episode without medication? Please circle.
  1. Negligibly
  2. Mildly
  3. Moderately
  4. Substantially
  5. Extremely

- How long will the child require services?

  _____

- Are there any specific medical accommodations you recommend for the child, relative to the health concern/illness/disability identified above?

  _____
  _____
  _____

- Other concerns:

  _____
  _____

Name of person completing this form (Please Print, then Sign and Date)

_____ _____ _____

(print name) (signature) (date)

******Parent******

Please return this form to Mrs. Lindsay Burns prior to the Chapter 15 meeting.