JEFFERSON COUNTY SCHOOL DISTRICT 509J
Request for Medical Information
Section 504 Evaluation

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. If the person indicated is not the student's parent/guardian, a Release of Information Consent form is attached. 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?

_____ Walking _____ Speaking _____ Seeing

_____ Breathing _____ Reading _____ Learning

_____ Hearing _____ Thinking _____ Concentrating

_____ Other Bodily Functions _____ Other: ________

How are the life activities affected?

3. Medical Treatment Plan (include medications, assistive devices), please enclose/include plan:

4. Does this student require special measures in order to access his/her education? (accessibility, instructionally, behaviorally, and/or socially/emotionally) Please explain.

5. What would help this student in the school setting?

__________________________ __________________________ _________________
Signature of Health Care Provider Printed Name Date

Please return to:

____________________________________ ______________________________________
Name/Title School

____________________________________ ______________________________________
Address Telephone Number

C: Student's cumulative file, parent(s)/guardian(s)