

Physician Questionnaire for Medical Concerns

Student name: ID #:

Date of birth: Grade: School:

Parent/guardian name:

Address: Apt/lot #:

City: State: Zip code:

Phone (home/cell/work): ( ) ( ) ( )

Detail available medical background including a written diagnostic statement and copies of any/all reports:

In your opinion, how do these difficulties “substantially limit” the student’s ability to receive and benefit from learning?

Detail the treatment plan including any prescribed medications:

Physician’s name: Phone: ( )

Physician’s address:

Physician’s signature: Date:

\*Attached permission for release of exchange information form signed by parent/guardian.