Request for Medical Information for Section 504 Evaluation – Form 504 F

Date: _______________________

Health Care Provider/Facility: ____________________________________________________

Address: _______________________________________________________________________
______________________________________________________________________________

Student’s Full Name: ____________________________________  Date of Birth: ___________

Dear Health Care Provider:

The above named student has been referred for evaluation and consideration of eligibility for Section 504 accommodations due to physical or mental impairment. Please provide the following information and return to the person indicated below. If the person indicated is not the student’s parent, a Consent for Release of Information – Form 504 E is attached. Thank you for your timely provision of this information.

1. Student’s medical diagnosis ______________________________________________________
   a. Is the disability/impairment temporary?  □ yes  □ no
   b. If temporary, what is the anticipated duration? _________________________________

2. Please check which major life activities, or identify which other bodily functions are affected:
   □ Seeing  □ Reading  □ Learning
   □ Hearing  □ Thinking  □ Walking
   □ Speaking  □ Concentrating  □ Breathing
   □ Caring for Oneself
   □ Other: ________________________________________________________________
   □ Other Bodily Functions: _________________________________________________
Please explain how the disability or impairment affects the major life activity or bodily function:

3. Medical treatment plan (include medications and/or assistive devices): *Attach pages as necessary.

4. Recommendations or additional comments: *Attach pages as necessary.

________________________________________________________     _____________
Signature of Physician/Health Care Provider                      Date

________________________________________________________
Printed Name

Please return to:

________________________  __________________________  _________________
Name                               Title                          School

_____________________________________
Address

__________________________________________
Telephone Number                     Fax number

Directions for Case Manager: While a medical diagnosis is not required to support the existence of a Section 504 disability, information about an existing medical diagnosis may be helpful to the evaluation and eligibility process. You may use this form to seek information from the health care provider with the parent’s consent (see Consent for Release of Information – Form 504 E). Seeking the medical information does not prevent the evaluation process from continuing.