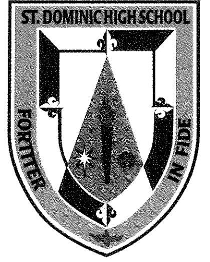
ST. DOMINIC HIGH SCHOOL

Prayer, Study, Community and Service Since 1929



Diagnostic Information Form

TO BE COMPLETED BY THE TREATING OR DIAGNOSING PROFESSIONAL

Student Name:____________________________________ DOB: ________________

Diagnostic Information

Diagnosis/DSM Code:____

Date of Initial Diagnosis:____

Diagnostic Criteria/Tests Used:____

____

____

____

____

Secondary Diagnoses (if applicable):______________________________________

____

Medication/Treatment Information

Current Medication(s):____

Dosage: _______________ Frequency: _______________ Where: _(Home / School)_

Side Effects: ____

Information Supporting Requests for Accommodations

Describe the student's functional limitations in an educational setting:_______________

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Regional Catholic High School serving St. Charles, Lincoln and Warren counties

Do you have any recommendations regarding academic accommodations and/or services to be implemented in the school setting?____

Do you have any recommendations regarding academic accommodations to be implemented on standardized tests? ____

Certifying Authority

Name ____

Title: ____

Address ____

____

Phone ____

Fax ____

Signature:________________________________ **Date:**__________________