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SCHOOL CENTER DISTRICT

504 REQUEST FOR MEDICAL INFORMATION

Student Name: _____ Student DOB: _____

The above named student has been referred for potential eligibility under Section 504 due to determine if he/she has a physical or mental impairment that substantially limits one or more major life activities. **Please complete the following information and return this form to the person listed below.** If the person indicated is not the student's parent, a signed HIPPA Release Form is attached. Thank you for your attention to this matter.

1) Medical Diagnosis: _____
   a. Is the disability/impairment temporary? ☐ Yes ☐ No
      If yes, what is the anticipated duration? _____
   b. Is the disability episodic (a permanent condition that can come and go)? ☐ Yes ☐ No

2) Which major life activities are affected? How?

☐ Seeing	☐ Learning	☐ Breathing
☐ Neurological	☐ Communicating	☐ Digestive System
☐ Endocrine System	☐ Interacting with others	☐ Thinking/ Concentrating
☐ Performing manual tasks	☐ Fine/Gross Motor Limitations	☐ Other: _____
☐ Other: _____		

3) If a major life activity was selected, please explain:
_____
_____
_____

4) **Medical Treatment Plan (include medications and/or assistive devices):**

5) **Recommendations or additional comments:**

_____ _____ _____/_____/_____
Signature of Doctor/Provider Printed Name Date

Please return this document to:
Name/Title: _____/_____
Telephone: _____
Fax: _____ Email: _____