D155
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Community High School District 155

MEDICAL CERTIFICATION FOR 504 PLAN REQUEST

To qualify under Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act of 1990, a student must (i)have,(ii) have a record of, or (iii) be regarded as having, a physical or mental impairment which substantially limits one or more major life activities—including but not limited to, learning, walking, seeing, hearing, speaking, eating, sleeping, standing, lifting, communicating, concentrating, reading, breathing, working, bending, thinking ,caring for one's self, and performing manual tasks. (See 34 C.F.R. Section 103.3)

To the physician completing this form,

Thank you for your time and consideration in your completion of this form. If you should require assistance or further information, please contact:

Name	Telephone	Email

To Be Completed By Parent/Guardian:

Student:_____ DOB:_____ Date:_____

I release_____, the physician who diagnosed and is treating
Print the name of physician

my student for_____ to complete this form.
Print the name of the mental or physical impairment

If necessary for the completion of a 504 Case Study Evaluation, I release District 155 to request additional written and verbal information from this physician and I release this physician to provide this information to District 155. I understand that this consent does not continue indefinitely, but will be valid until the end of the current school year.

Printed name of parent	Signature of parent	Date

Printed name of student	Signature of student	Date

To Be Completed By A Licensed Physician

Psychiatric or Medical Diagnosis:_____
Did you make the diagnosis of this patient?

☐ Yes Date of diagnosis:_____

☐ No The physician who made this diagnosis and the date:

_____ _____
Print name of physician Date

This student has been under my care for the above named condition since_____,
and has been seen in my office_____ times for this condition.

Any information you can provide regarding the tests or techniques used to arrive at this diagnosis including the dates of evaluation and test results with subtest scores and observations would be considered helpful and appreciated. (Please attach any available copies of evaluation/test results.)

Please describe how the student's impairment impacts daily functioning:

Please list all medications, treatments, therapies, or programs that you have prescribed/recommended for the treatment of this condition:

_____ _____ _____
Printed name of Physician Signature of Physician Date

_____ _____ _____ _____
Street Address City State Zip

_____ _____
Telephone Number Fax