MT. PLEASANT CENTRAL SCHOOL DISTRICT

825 WESTLAKE DRIVE
THORNWOOD, NY 10594
FAX # 914-769-4608

COMMITTEE ON SPECIAL EDUCATION/SECTION 504

(TO BE COMPLETED BY THE PROFESSIONAL PROVIDING DIAGNOSIS)

Name of Student: _____

Physician's Name & Address: _____

_____

_____

_____ I can confirm that the criteria for student's medical condition:_____

_____have been met based upon:

Diagnosis Code/Description: _____/_____

_____/_____

_____/_____

Date of Diagnosis:_____

I have utilized the following diagnostic material(s):

_____Medical, developmental, behavioral, social/family history

_____School records and history

_____Physical examination

Other_____

Other_____

Other_____

Other known/suspected associated problems:

_____Medical _____Psycho-social/environmental

_____Neuro-developmental _____Learning _____Behavioral/emotional

Physician's Name (PLEASE PRINT)_____

Physician's Signature_____Date_____