Fayette County Public Schools

Physical/Mental Health Questionnaire For 504 Eligibility Consideration

Student Name: _____ **Date of Birth:** _____ **Grade:** _____ **Age:** _____

I give permission for Fayette County School District to request confidential information concerning my son/daughter to the physician, mental health and or medical professional listed below.

Parent Signature: _____

1. Detail available relevant medical background, including a written diagnostic statement with the current ICD Medical Diagnosis and Code or the current DSM Diagnosis and Code.
   _____
   _____
   _____
2. In your opinion, do these difficulties "substantially limit" this student's ability to access, receive and benefit from learning or school activities? If yes, how?
   _____
   _____
   _____
3. Recommendations for consideration at upcoming conference.
   _____
   _____
   _____
4. Does the student need a health service accommodation to prevent a life threatening or serious health reaction/situation in the school environment? If so list what precautions are recommended for consideration at an upcoming 504 conference
   _____
   _____
   _____

Please attach any reports pertinent to the educational/health needs of this child in the school setting.

Printed name of medical or mental health professional, title and qualifications:_____

Signature of medical or mental health professional:_____

Date of report: _____

Name and address of Office: _____

Phone: _____ Email: _____

Please complete, sign, and return original form to:

Name of School: _____Attn:_____
Address: _____
Fax: _____ City _____ State _____Zip _____