Fulton County Schools
Section 504
MEDICAL FORM

School______________________________

Date Requested _____________________

STUDENT: ____ **DOB:** ____/____/____
DATE: ____/____/___

SCHOOL: ____ **TEACHER:** _____________________________
(Referring Teacher/Agency)

ADDRESS: ____ **TELEPHONE:** ___________________

MEDICAL INFORMATION (To be completed by licensed physician)

Diagnosis:
____

Prognosis:
____

Medication and Dosage: ____

Special health care procedures, diet or activity restrictions:
____

SURGERY Type of Surgery Date Results

______________________________ ____/____/____
____

______________________________ ____/____/____
____

MEDICAL IMPLICATIONS FOR INSTRUCTION: (To be completed by licensed physician)

Please indicate how the medical condition causes reduced efficiency in the student's school participation/performance in the following areas: (Include other areas as needed)

Attendance____
____

Attention
____
____

Physical
Function/Ambulation
____
____

Daily Living
Activities
____
____

Academic
Limitations
____
____

School
Participation
____
____

Communication
Abilities____
____

Other
Comments____
____

PLEASE ATTACH COPY OF APPROPRIATE MEDICAL RECORDS. Thank you.

PHYSICIAN'S NAME ___________________________________

PHYSICIAN'S SIGNATURE ___________________________________

Address ____TELEPHONE _____________________

DATE ____/____/____