



Norwell Public Schools

Office of Student Services • Health Services

Kelly Roche, R.N., Norwell High School • Jillian Young, R.N., Norwell Middle School
Kristen Isola, R.N., Vinal Elementary School • Jacqueline Cregg, R.N., Cole Elementary School



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Dear Parents/ Guardians~

As part of the process for a comprehensive evaluation, Norwell Public Schools is proposing the completion of a Medical Assessment. This assessment is essential to the team when they meet to determine the eligibility for Special Education and/or related services.

The Medical Assessment allows the team to “rule out” the presence of any medically relevant information that may explain any potential difficulty. Alternatively, the Medical Assessment may provide valuable information to the team when developing a comprehensive picture of the student's progress and functioning.

Attached to this letter is the Medical Assessment, which the district is proposing to be a part of this Initial (or Re-)Evaluation team meeting. Should you consent to this evaluation,
please ask your child's primary care physician or pediatrician to complete it and return it
to the school at your earliest convenience.

If you require any additional assistance, please do not hesitate to contact me directly by phone or email.

Sincerely~

Kelly Roche, BSN, R.N.-C, MSN, C.A.G.S.

Kelly Roche MSN, BSN, RN-BC, CAGS
Norwell High School
School Nurse

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Medical Assessment

Pursuant to 603 CMR 28.04

To: Office of Student Services-Health Services

From: Child's Physician

Directions: This form should be completed and signed by a physician licensed to practice in the Commonwealth of Massachusetts. It may be used as a comprehensive report of relevant findings or as the cover sheet for an attached narrative medical report. It should be returned:

To: _____ by _____
(School Nurse) (Date)

Student's Name: _____ Tel.#: _____

Address: _____
(Street City/Town State Zip Code)

Physician's Name: _____

Address: _____
(Street City/Town State Zip Code)

DATE OF EXAMINATION: _____

Check One: ☐ Primary Care ☐ Consultant ☐ School Physician ☐ Other

If a consultant, please specify specialty: _____

Please answer the following questions and complete, where appropriate, a narrative explanation of your responses:

1. Are there aspects of this student's health-related history that have a bearing on his/her educational needs?

☐ Yes ☐ No ☐ Possibly Please describe. ☐ See Below ☐ See Narrative
Narrative:

2. Are there findings on this student's standard physical examination that might affect educational planning?

☐ Yes ☐ No ☐ Possibly Please describe. ☐ See Below ☐ See Narrative
Narrative:

3. Are there specific neurological, sensory or other handicapping conditions noted? Please describe, and If possible, note how these may affect educational planning?

☐ Yes ☐ No ☐ Possibly Please describe. ☐ See Below ☐ See Narrative
Narrative:

4. Is the student receiving any medications and/or other therapies that might affect educational planning?

☐ Yes ☐ No ☐ Possibly Please describe. ☐ See Below ☐ See Narrative
Narrative:

5. Are there any educationally relevant developmental findings resulting from your examination?

☐ Yes ☐ No ☐ Possibly Please describe. ☐ See Below ☐ See Narrative
Narrative:

6. Do you have any general observations or knowledge of this student that might be helpful?

☐ Yes ☐ No ☐ Possibly Please describe. ☐ See Below ☐ See Narrative
Narrative:

7. Do you have any recommendations or suggestions for this student's educational plan? Please include any limitations or constraints on participation in various school activities.

☐ Yes ☐ No ☐ Possibly Please describe. ☐ See Below ☐ See Narrative
Narrative:

8. Can this student participate in the regular physical education program?

☐ Yes ☐ No ☐ Possibly
If not, what modifications would you recommend? ☐ See Below ☐ See Narrative

9. Do you feel it would be important for you to attend the evaluation TEAM meeting? Can you suggest any times that are most convenient for you?

☐ Yes ☐ No ☐ Possibly Days _____ Times _____
It may not be possible to conduct the meeting at these times. If it is not possible for you attend
Who will serve as your designee?
Name: _____

10. Do you wish to have a copy of this student's educational plan for your records? ☐ Yes ☐ No

11. Please identify any **individually medically necessary** accommodations that the student should be provided in order to access the educational program (please be as specific as possible):

(Signature)

(Date)