

Physician Input Form – Fox Chapel Area School District

Section 1: Contact Information

Student's Name: _____	Physician's Name: _____
Physician's Address: _____	Physician's Phone: _____
Medical Diagnosis: _____	

Section 2: Instructional Environment & Participation

Is the student able to participate in instruction in the school environment?	☐ Yes ☐ Yes, with limitations. Please explain: _____ ☐ Not able to attend school. (If checked, please complete enclosed PDE Form 203.)
Is the student able to participate in instruction outside of the school environment? (Up to 5 hours per week)	☐ Yes ☐ Yes, with limitations. Please explain: _____ ☐ No

Section 3: Accommodations That May Be Needed

Shortened school day:	☐ Yes ☐ No
Test accommodations (e.g., extended time, quiet setting):	Please specify: _____
Assignments modified:	Please specify: _____
Other accommodations:	Please specify: _____

Section 4: Date and Signature

Date: ____ / ____ / _____	Physician's Signature: _____
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Important Requirements & Notes:

- Please use the back of this form if additional space is required to explain limitations or modifications.
- This information must be updated after 90 days.