Medical Verification of Physical Impairment or Other Health Impairment

Bloomfield Hills Schools

STUDENT DETAILS

Student Name _____ Date of Birth _____

Grade _____ School _____

The form below is to be completed by physician. You may attach additional support information to this form. Return form to the main office of student's school.

1. Does the student have a severe orthopedic impairment? ☐ yes ☐ no

Specify medical diagnosis: _____

2. If you answered "yes" to question 1, please check the statement that applies:

- ☐ This orthopedic impairment is unlikely to change significantly over time.
- ☐ This orthopedic impairment is subject to improvement over time.
- ☐ This orthopedic impairment is subject to deterioration over time.
- ☐ This orthopedic impairment is subject to change in some other way over time.

3. Does this student have a chronic or acute health condition? ☐ yes ☐ no

Specify medical diagnosis: _____

4. If you answered "yes" to question 3, please select any statements that apply:

- ☐ limited strength ☐ limited vitality ☐ limited alertness
- ☐ heightened alertness to environmental stimuli

5. If you answered "yes" to question 3, please check the statement that applies:

- ☐ This health condition is unlikely to change significantly over time.
- ☐ This health condition is subject to improvement over time.
- ☐ This health condition is subject to deterioration over time.
- ☐ This health condition is subject to change in some other way over time.

Please identify any additional medical conditions or health-related factors the school should be aware of:

_____

Physician's Signature _____ Date _____

Physician's Name, Address, Phone: