HENRY COUNTY SCHOOLS
33 N. Zack Hinton Pkway
McDonough, GA 30352
Phone: 770.957.6601

IN PURSUIT OF EXCEPTIONAL

Section 504 Physician's Verification of Health Impairment

Psychological Services/Section 504 Department

Student Name:	
Student ID Number:	
Date of Birth:	
School:	
Grade:	
Parent(s)/Guardian(s)	
Address:	
Phone Number	

The above-named student has been referred for potential eligibility under Section 504 due to a physical or mental impairment. Please complete the following information and return it to the parent and/or person indicated below. The parent provided their signature permitting the school to receive this information.

Physician Statement and Diagnosis
To Be Completed by an (M.D. or D.O)

Patient Diagnosis/Summary of Medical Impairment

_____

_____

_____

Does the student have a physical or mental impairment that may interfere with the student's school functioning?

☐ Yes ☐ No

Check all descriptions that may interfere with the student's school functioning:

	Frequent absences		Limited ability to move about
	Lack of strength		Limited ability to sit
	Lack of vitality		Limited ability to manipulate items
	Lack of alertness		Limited ability to concentrate
	Limited vision		Limited ambulation
	Limited hearing		Limited posture
	Limited ability to initiate tasks		Limited body use
	Limited ability to organize		Other: _____

Prognosis/Precautions: _____

Additional information regarding this student's disabling condition:

_____

_____

_____

_____

HENRY COUNTY SCHOOLS
33 N. Zack Hinton Pkway
McDonough, GA 30352
Phone: 770.957.6601

IN PURSUIT OF EXCEPTIONAL

Does the student require special health care (i.e., special diet, and/or activity restrictions? ☐ Yes ☐ No
Description of special health care for emergency procedures:

_____
_____
_____

Will the student require ongoing treatment/therapy for this condition? ☐ Yes ☐ No
Special instructions regarding physical and/or occupational therapies:

_____
_____
_____

MEDICATIONS

Will the student take medication for this condition? ☐ Yes ☐ No
If the student will be medicated, please provide information about each medication below.

Name of the Medication and dosage (or attach list)	Effects on student's ability to comprehend	Effects on student's ability to complete independent assignments	Effects on student's ability to relate to teachers and other students

Parent's Signature:	
Print Doctor/Specialist Name:	
Signature of Doctor/Specialist:	
Date:	

Physician's/Specialist Name:	**Fax to: Person Requesting Information**
Name of Physician's Practicing Office/Hospital:	School Name:
Address:	School Address:
Email:	Requestor Email:
Phone Number:	School Phone Number
Fax Number:	School Fax Number: