Fayette County Public Schools

PHYSICIAN QUESTIONNAIRE FOR 504 Eligibility

Student Name:	Date of Birth:	Date:
School:		

I give permission for Fayette County School District to request confidential information concerning my son/daughter to the physician, mental health and or medical professional listed below.
Parent Signature: ____

1. Detail available relevant medical background, including a written diagnostic statement with the current ICD9 Medical Diagnosis and **Code** or the current DSM IV Diagnosis and **Code**.
   ____
   ____
   ____

2. In your opinion, do these difficulties "substantially limit" this student's ability to access, receive and benefit from learning or school activities: even if episodic or in remission, without regard to the ameliorative effects of mitigating measures, except for ordinary eyeglasses or contact lenses? If yes, how?
   ____
   ____
   ____
   ____

3. Recommendations for consideration at upcoming conference. ______________________________
   ____
   ____
   ____

4. Does the student need a health service accommodation to prevent a life threatening or serious health reaction/situation in the school environment? If so list what precautions are recommended for consideration at an upcoming 504 conference ____
   ____
   ____
   ____

<u>Please attach any reports pertinent to the educational/health needs of this child in the school setting.</u>

Medical or Mental Health Professional Signature ______________________Date of Report: ___________
Printed name of professional/title: ____
Office address: ____Phone _______________________
Please forward this copy to:

Name of School:	Attn:		
Address:			
Fax:	City	State	Zip

C: School, Parent, 504 Coordinator

Revised 12/11