Request for Medical Accommodations to be Completed By Treating Physician

Physician Instructions: Please complete this form and return it to your patient's parent or fax to patient's school at _____.
If you have questions, please contact _____.

_____is under my care for _____.
(Student's Name) (Diagnosis)

What limitations does this diagnosis cause? (e.g. severely limits ambulation)

_____

_____

_____

How does this limitation affect the student's ability to attend and participate in class?
(e.g. requires constant medical attention)

_____

_____

_____

How does this limitation affect the student's ability to take transportation?
(e.g. increases risk for fractures)

_____

_____

_____

Expected duration of the limitation _____

Please provide any recommendations to accommodate the student's needs in the classroom and/or during school transportation (please attach additional sheets as needed):

_____

_____

_____

I request transportation accommodations to be provided for _____ weeks

I can be reached at: Tel#_____ and/or Beeper _____on:
Mon_____ (hrs) Tue_____ (hrs) Wed_____ (hrs) Thu_____ (hrs) Fri_____ (hrs)

Provider's Original Signature_____ License #_____

Print Name / Degree
_____ Date_____

Parent Consent for Release of Medical Information

Please complete the attached Authorization for Release of Health Information Pursuant to HIPAA. This form is necessary in the event additional information is required from your physician to approve the request for medical accommodations.
FOR SCHOOL USE ONLY

Student's Name _____DOB_____ID # _____