Livonia Public Schools

FORM H

SECTION 504 - PHYSICIAN'S STATEMENT

Student Name: _____ Date of Birth: _____

Physician's Section. Please provide the following information to assist the School District in its Section 504 evaluation. Attach supporting documentation if needed.

1. Does the student have a physical or mental impairment? Yes _____ No ____ If yes, what is the student's diagnosis?

_____
_____
_____

2. Describe the student's current prognosis and the nature and extent of possible change in the student's condition?

_____
_____
_____

3. What are the anticipated effects of the physical or mental impairment on the student's ability to access, participate in, or benefit from school/educational experience?

_____
_____
_____

4. Does the student have any other special health/medical issues of which the School District should be aware which could affect the student in the school setting?

_____
_____
_____

5. Is the student currently on any medication of which the School District should be aware?
Yes _____ No _____ If yes, please list medication(s), dosage, and frequency.

_____
_____

6. Additional comments to assist in educational planning for student.

_____
_____

Physician's Signature _____ Date _____

Physician's Name: _____ Phone: _____
Address: _____ Email: _____
_____