FORM L
MEDICAL PROVIDER QUESTIONNAIRE

Student:		**School:**
Grade:	**DOB:**	**Date Form Provided to Parent or Physician:**

Date Release of Information was signed _____ (Attached)

Please fax or email information to _____

FOR MEDICAL PROVIDER TO COMPLETE:

*****PLEASE USE A SEPARATE FORM FOR EACH DIAGNOSIS***

Diagnosis:_____ **Date of Diagnosis:**_____

First Medication to Address Diagnosis: _____ Start Date(s): _____

- Dosage?_____
- How often? _____
- What is/was the medication meant to alleviate?_____

Second Medication to Address Diagnosis: _____ Start Date(s): _____

- Dosage?_____
- How often? _____
- What is/was the medication meant to alleviate?_____

Additional Questions:

1. How many times have you seen this student for this diagnosis? _____
2. How long was each visit, on average?_____

3. What data/information did you utilize to make this diagnosis?

☐ I understand the above referenced information is critical to the Student's multidisciplinary 504 team, and I have attached a copy of the above referenced data/information.

4. In what way/s does the student's diagnosis affect his/her body and/or mind?

To what degree is the student affected?

5. Does the student's diagnosis affect his/her ability to perform any specific activities? If so, please list those activities.

To what degree is the student affected?

6. I understand that Section 504 eligibility, and necessary supports and accommodations are a **team decision**. I request the Section 504 team consider the following recommendations:

The above recommendations should be in effect until (date or event): _____

Authorized Health Care Provider Signature _____

Authorized Health Care Provider Name (print clearly) _____

Telephone No._____ Date_____