Humphreys County School

Medical Information

Student _____ School _____

Date of Birth _____/_____/_____

Parent(s)/Guardian _____

Phone _____/_____/_____ Address _____

Dear Physician:

This student is being evaluated by Humphreys County Schools to determine if additional educational services are needed due to a possible medical condition that might significantly impact school performance. The information below is a necessary part of the evaluation to help the IEP Team determine whether or not the student requires in-class interventions, direct or related services in Special Education and/or other services in order to progress in the general curriculum. The information will be confidential and used only by persons directly involved with the student.

(Please respond to each item).

Diagnosis/Etiology: _____

Prognosis: _____

Is an evaluation available supporting the above diagnosis? ❑ Yes....❑ No

Please describe the impact of diagnosis on educational performance: _____
_____
_____

Treatment: _____
_____

Medication: (+Dosage): _____
_____

Type: _____

Major Learning Modality: (Check Applicable)
❑ Visual ❑ Auditory ❑ Tactile ❑ Multisensory

Please make the most appropriate recommendation as to how this student can best function in an educational environment:

_____
_____
_____

Date of Examination/Evaluation: _____

Physician's Name (please print): _____
Authorized Signature: _____