MEDICAL REVIEW FOR 504 ACCOMMODATIONS 2016-2017

Name of Student _____ DOB ___/___/___ Student ID# _____

School Name _____ School ATS/DBN: _____ Grade/Class _____

To be completed by the Student's Health Care Practitioner

1. Medical Diagnosis/Disability/ICD-10 Code/DSM-V Code(s): _____.___ _____.___ _____.___

□ AD – Attention Deficit/ Hyperactivity/Conduct □ AL – Allergy/Food/Medication □ AS – Asthma/Airway Disease □ BL – Anemia/Blood Disorder	□ CA – Cancer □ CV – Cardiovascular/Syncope □ DI – Diabetes/Glycogen Storage □ EA – Ear/Hearing	□ EY – Eye/Vision □ GI - Gastrointestinal □ MO – Mobility Impairment □ NU – Neuro/Epilepsy/Seizures	□ SK – Skin Disorder □ Other

2. Is this a temporary condition? ☐ Yes ☐ No Specify estimated duration of condition: _____ weeks

3. Requested Accommodations: please complete table below.

If request is for a diagnosis of allergies/anaphylaxis, diabetes, or seizure disorder, please also review and complete the applicable section(s) on the back of this form.

Diagnosis/Condition	Accommodation	Expected Duration (weeks)	How does diagnosis affect educational performance? *(attach addendum if needed)*
1.	□ Air Conditioning □ Ambulation Assistance □ Elevator Pass □ Paraprofessional □ Other: _____		
2.	□ Air Conditioning □ Ambulation Assistance □ Elevator Pass □ Paraprofessional □ Other: _____		
3.	□ Air Conditioning □ Ambulation Assistance □ Elevator Pass □ Paraprofessional □ Other: _____		

*If the requested accommodation is for a paraprofessional, please list the tasks/responsibilities the paraprofessional must perform in order to support the student. **Note:** *paraprofessionals may not give insulin or supervise insulin administration.*

4. Have the appropriate orders (medications and/or procedures) been completed for school treatment? Yes ☐ No ☐ N/A ☐

If no, please specify/explain:

Health Care Practitioner Information

Health Care Practitioner (Please Print) LAST NAME		FIRST NAME	Signature
Address		Tel. (___)___-____	Fax. (___)___-____
E-mail address*		Cell* (___)___-____	
NYS License # **(Required)** _____	Medicaid# __ __ __ __ __ __ __	NPI # __ __ __ __ __ __ __ __ __ __	Date __/__/____

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To Completed by the Student's Health Care Practitioner

Allergies/Anaphylaxis
(note Available School-Specific Allergy Resources listed below)

List allergen(s): _____
_____
_____

Source of allergy documentation: □ Skin Testing □ Blood Test □ Parental Report
History of Anaphylaxis? □ Yes □ No
If yes, specify symptoms: □Respiratory □ Skin □ GI □ Cardiovascular □Neurologic
Medications _____
_____

Was an **Allergy/Anaphylaxis MAF** completed? □ Yes □ No
Does the student have a history of developmental or cognitive delay? □ Yes □ No
If yes, specify diagnosis/diagnoses _____
Does the student have prior experience with self-monitoring? □ Yes □ No
Can the student:

- □ Independently self-monitor and self-manage?
- □ Recognize symptoms of an allergic reaction?
- □ Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?
- □ Follow safety measures established by a parent/guardian and/or school team?
- □ Understand not to trade or share foods with anyone?
- □ Understand not to eat any food item that has not come from or been approved by a parent/guardian?
- □ Wash hands before and after eating?
- □ Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?
- □ Carry an epinephrine auto-injector?

Provider Signature_____

Diabetes

When was the student diagnosed with diabetes? ___/___/___
Are current DMAF orders on file at school for this student? □ Yes □ No
Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? If yes, please specify: □ Yes □ No
_____
_____
Can the student identify symptoms of hypoglycemia? □ Yes □ No
Can the student notify an adult when they feel that their blood glucose is not normal? □ Yes □ No
What is the plan to transition the student to independent functioning?

Provider Signature:_____

Seizure Disorder

Type of Seizure _____
Frequency of Seizures _____
Medication(s), including emergency medications _____
_____
Are the seizures well-controlled by the current medication regimen? □ Yes □ No
Does the student require routine or prn emergency medication in school? □ Yes □ No
If yes, has an MAF been completed? □ Yes □ No
Other Associated Symptoms, including medication side effects _____
_____
Number of seizure-related ER visits during the past year _____
Number of seizure-related hospitalizations/ICU admissions _____
Frequency of office visits/monitoring _____ □weeks□ months
Last Office Visit ___/___/___
Activity Restrictions _____

Provider Signature_____

School Use Only

Available School-Specific Allergy Resources

- □ Allergy Table(s) in the lunchroom: _____ staff members for supervision
- □ Allergy Table(s) in the classroom: _____ staff members for supervision
- □ General Staff Training for Epinephrine administration: _____ staff members trained
- □ Student-Specific Training for Epinephrine administration: _____ staff members trained
- □ Allergy Response Plan
- □ Other: _____

Name of Principal or Principal's Designee: _____