MEDICAL REVIEW FOR 504 ACCOMMODATIONS 2016-2017

Name of Student				DOB	1	1	Student ID#	‡	
			School ATS	S/DBN:			Grade/Class	S	
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 – Cardiov □ DI – Diabetes □ EA – Ear/Hea	ascular/Sync s/Glycogen St	ope torage	□ 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 e			stimated dur	ration of	condition	າ:	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 D		Expected Duration (weeks)	tion How does diagnosis affect educational performance? (attac					
1.	Air Conditioning Ambulation Assist Elevator Pass Paraprofessional Other:								
2.	Air Conditioning Ambulation Assist Elevator Pass Paraprofessional Other:								
3.	Air Conditioning Ambulation Assist Elevator Pass Paraprofessional Other:		li at th	Angles (m. c		[14] a a 41a			
*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:									
ealth Care Practitioner Information									
Health Care Practitioner LAST NAME FIRST NAME Signature (Please Print)									
Address			Tel. (Fax. ()		_			
E-mail address*			Cell* (_	Cell* ()					
NVC License # (Deguired)			NDI #	NDI#					

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List allergen(s):									
Source of allergy documentation: Skin Testing		Resources listed below)							
History of Anaphylaxis MAF completed? If yes, specify symptoms:									
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# Yes, spacify symptoms: # Yes, spacify symptoms: # Wes an Allergy/Anaphylaxis MAF completed? # Yes as No # Does the student have a history of developmental or cognitive delay? # Yes as No # Independently self-monitor and self-manage? # Recognize symptoms of an allergic reaction? # Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? # Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty inform an adula as soon as accidental exposure occurs or symptoms appear, or ask a friend for help? ## Prompty information adula as a friend for help? ## Prompty information adula as a friend for help? ## Prompty information adula as a friend for help? ## Prompty information adula as a friend for help? ## Prompty information adula as a friend for help? ## Prompty information adula as a friend for help? ## Prom		,							
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