

MEDICAL STATEMENT OR HEALTH ASSESSMENT STATEMENT

Child's Name: _____ Child's Birthdate: _____

Return to: _____ Date needed: _____ Fax # _____

This child has been referred to determine special education eligibility. Oregon law requires that a medical statement or health assessment be obtained for some disabilities. **This information is urgently needed** to determine appropriate services for the child and **to comply with federal timelines** for the special education evaluation. Please answer all questions in row(s) with checked boxes and sign below.

1. <input type="checkbox"/>	<p>Does child have a vision problem? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, check each of the following that apply:</p> <p><input type="checkbox"/> Child's residual acuity is 20/70 or less in the better eye with correction.</p> <p><input type="checkbox"/> Child's visual field is restricted to 20 degrees or less in the better eye.</p> <p><input type="checkbox"/> Child has an eye pathology or progressive eye disease that is expected to reduce residual acuity or visual field to one of the criteria listed above.</p> <p><input type="checkbox"/> Assessment results are inconclusive and child demonstrates inadequate use of residual vision.</p> <p>Additional information about the vision problem(s).</p>															
2. <input type="checkbox"/>	<p>Does child have a hearing problem? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, complete the following:</p> <p><input type="checkbox"/> Child has a sensory-neural hearing loss.</p> <p><input type="checkbox"/> Child has a conductive hearing loss that: <input type="checkbox"/>is <input type="checkbox"/> is not treatable.</p> <p><input type="checkbox"/> The use of amplification: <input type="checkbox"/>is <input type="checkbox"/> is not appropriate.</p> <p>Additional information about the hearing problem(s).</p>															
3. <input type="checkbox"/>	<p>Does child have a voice disorder? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, additional information about the voice disorder is needed.</p>															
4. <input type="checkbox"/>	<p>Does child have relevant medical issues that contribute to speech/language problem? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, a description of the medical issue(s) contributing to speech or language problem is needed.</p>															
5. <input type="checkbox"/>	<p>Does child have an impairment that is expected to last more than 60 calendar days? (Mark all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">▪ Autism Spectrum Disorder</td> <td style="width: 10%;"><input type="checkbox"/>Yes</td> <td style="width: 10%;"><input type="checkbox"/>No</td> </tr> <tr> <td>▪ Health Impairment</td> <td><input type="checkbox"/>Yes</td> <td><input type="checkbox"/>No</td> </tr> <tr> <td>▪ Orthopedic Impairment</td> <td><input type="checkbox"/>Yes</td> <td><input type="checkbox"/>No</td> </tr> <tr> <td>▪ Motor Impairment</td> <td><input type="checkbox"/>Yes</td> <td><input type="checkbox"/>No</td> </tr> <tr> <td>▪ Traumatic Brain Injury caused by an external force</td> <td><input type="checkbox"/>Yes</td> <td><input type="checkbox"/>No</td> </tr> </table> <p>If yes, a diagnosis or a description of the impairment(s) identified above is required.</p>	▪ Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	▪ Health Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	▪ Orthopedic Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	▪ Motor Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	▪ Traumatic Brain Injury caused by an external force	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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▪ Traumatic Brain Injury caused by an external force	<input type="checkbox"/> Yes	<input type="checkbox"/> No														
6. <input type="checkbox"/>	<p>Has child been diagnosed with <u>other</u> physical, medical, sensory or mental health condition(s) that may affect his/her educational performance? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, the diagnosis and a description of the diagnosis are required.</p>															

Medical/Health Professional's Signature & Title: _____ Date: _____

Medical/Health Professional's Printed Name & Title: _____