PORTLAND PUBLIC SCHOOLS

Student Services

Clear Form

Medical Statement or Health Assessment Statement

Please return to:	Date of Assessment:
	Child's Name:
	Birthdate:

To the physician or health practitioner: This medical statement will be used to assist in determining eligibility for educational support due to a temporary medical, Section 504 disability accommodations or other disability-related supports for the student. Please attach documentation as needed. Consent for release of information is enclosed.

1. Does the student have a physical or mental impairment? ☐ Yes ☐ No If yes, what is the student's diagnosis and how long is the condition expected to last?
2. Describe the student's current prognosis and the nature and extent of possible change in the student's condition?
3. What are the anticipated effects of the student's impairment on the student's ability to access, participate in, or benefit from school/educational experience?
4. Does the student have any restrictions on physical activity due to the medical condition? What is the estimated length of time these restrictions will be needed?
5. What medically necessary accommodations are needed, if any, for the student to access education due to the medical condition? What is the estimated length of time these restrictions will be needed?
6. Does the student have any other special health/medical issues of which the School District should be aware which could affect the student in the school setting?
7. Is the student currently on any medication of which the School District should be aware? ☐ Yes ☐ No If yes, please list medication(s), dosage, and frequency.
Additional comments to assist in educational planning for student:

Print Name/Title:	Phone:
	Address:
Signature:	Email:

8/2016