Jefferson County Public Schools

**Health/Medical Questionnaire Regarding Section 504 Eligibility**

Student's Name: _____ Date of Birth: _____ Grade: _____

**Parental Consent for Disclosure of Information:**

**I authorize the release of the results and recommendations from this office to Jefferson County Public Schools for use in determining my child's educational needs.**

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**Parent/Guardian Signature** **Date**

1. The above-named student has been referred for possible eligibility/identification under Section 504 of the Rehabilitation Act of 1973. Please provide available relevant medical background information below, **including a written diagnostic statement with the current ICD Medical Diagnosis and Code or Current DSM Diagnosis and Code and copies of any/all relevant reports.**

2. In your opinion, do these difficulties "substantially limit" this student's ability to access and benefit from learning and school activities? If yes, how?

3. Does the student need health service accommodation(s) to prevent a life-threatening or serious health reaction/situation in the school environment? If so, please list recommended precautions for consideration in the upcoming Section 504 meeting. Please attach any reports pertinent to the serious health needs of this child in the school setting.

_____ _____

**Signature of Physician or Qualified Professional** **Date**

_____ _____

**Office Address** **Phone**

**Please forward the completed form to:**

_____ _____ _____

**Section 504 Chairperson** **School** **Phone/Fax**

Section 504 Health/Medical Questionnaire