Medical Home↔School - Evaluation/Services Form

This form will serve as communication between the student's health care provider and school professionals as it relates to health concerns that may impact the student's education.

Contact information			
	Patient/Student's Full Name:	Parent/Guardian's Name:	Phone Number:
	Patient/Student's School & District:	Principal's Name (if known):	School Phone No.:
	❑ I, the undersigned, have authorized sharing of information by signing a Medical Home-School Information Release that is current and will remain in effect until the date indicated here: _____. Parent/Guardian's Signature: Date:		

Physician Contact Info			
	Medical Home Provider (MD, DO, PA, NP):	Phone Number:	Fax Number:
	Mailing Address:	E-mail address:	
	If not the above, who is the best contact person:	Phone Number:	
	Mailing Address:	E-mail address:	
	Preferred Method and Time for Contact:		

Diagnosis and Treatment		
	Student's condition/diagnosis: Date of onset:	
	Nature of current treatment/medication, if any: Side effects from treatment/medication (indicate current, expected, or possible, particularly as they may impact the classroom):	
	With this treatment the patient has: ❑ Recovered ❑ Improved ❑ Not changed ❑ Regressed ❑ Other-explain	With treatment, does the child have PHYSICAL Functional Limitations? ❑ Yes, If Yes, explain: ❑ No With treatment, does the child have MENTAL/EMOTIONAL Functional Limitations? ❑ Yes, If Yes, explain: ❑ No

Complete other side (page 2) of this form also

Patient/Student's Name: **School:**

Areas Affected by the Condition

Life Activities possibly affected:	**School Activities** possibly affected by this condition:	
❑ Caring for oneself ❑ Performing manual tasks ❑ Walking ❑ Seeing ❑ Hearing ❑ Speaking ❑ Breathing ❑ Learning ❑ Working	❑ School attendance ❑ Memory/attention ❑ Thirst/appetite ❑ Mobility/motor skills ❑ Peer interactions ❑ Personality ❑ Toileting/hygiene ❑ Stamina/fatigue ❑ Meals/feeding/foods ❑ Transportation	❑ Academic testing ❑ Physical education ❑ Field trips/events ❑ Playground/recess ❑ Oral expression ❑ Articulation ❑ Written expression ❑ Comprehension ❑ Transitions ❑ Other:
Explain:	Explain:	

Complete only the sections appropriate

NOTE: The following information will be considered by school teams to determine steps to be taken such as evaluation, services, accommodations or other considerations.

Recommended Evaluation(s) & Service(s)

Reason for recommendation:

Evaluation recommendations:	**School services recommendations** (please check category and provide detail if applicable):
❑ Autism ❑ Deafblindness ❑ Developmental Delay ❑ Emotional Disturbance ❑ Hearing Impairments/Deafness ❑ Intellectual Disability ❑ Multiple Disabilities ❑ Orthopedic Impairments ❑ Other Health Impairments ❑ Specific Learning Disabilities ❑ Speech/Language Impairment ❑ Traumatic Brain Injury ❑ Visual Impairment (Including Blindness) Comments:	❑ Dietary accommodations ❑ Personal care ❑ Psychological services ❑ Medical procedures: ❑ Speech, vision, and/or hearing therapy consult ❑ Physical/occupational therapy consult ❑ Specially designed instruction ❑ Other – please explain: Comments:

Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations, etc.)

Other concerns not previously addressed:

Medical Provider Signature	Date

Revised 10/13/2008