

MEDICAL REVIEW FOR 504 ACCOMMODATIONS 2017-2018

Name of Student _____ DOB ____ / ____ / ____ Student ID# _____
 School Name _____ School ATS/DBN: _____ Grade/Class _____

To be completed by the Student's Health Care Practitioner

1. Medical Diagnosis/Disability/ICD-10 Code/DSM-V Code(s): _____

<input type="checkbox"/> AD – Attention Deficit/ Hyperactivity/Conduct	<input type="checkbox"/> CA – Cancer	<input type="checkbox"/> EY – Eye/Vision	<input type="checkbox"/> SK – Skin Disorder
<input type="checkbox"/> AL – Allergy/Food/Medication	<input type="checkbox"/> CV – Cardiovascular/Syncope	<input type="checkbox"/> GI - Gastrointestinal	<input type="checkbox"/> Other
<input type="checkbox"/> AS – Asthma/Airway Disease	<input type="checkbox"/> DI – Diabetes/Glycogen Storage	<input type="checkbox"/> MO – Mobility Impairment	
<input type="checkbox"/> BL – Anemia/Blood Disorder	<input type="checkbox"/> EA – Ear/Hearing	<input type="checkbox"/> NU – Neuro/Epilepsy/Seizures	

2. Is this a temporary condition? Yes No Specify estimated duration of condition: _____ 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	Expected Duration (weeks)	How does diagnosis affect educational performance? (<i>attach addendum if needed</i>)
1.	<input type="checkbox"/> Air Conditioning <input type="checkbox"/> Ambulation Assistance <input type="checkbox"/> Elevator Pass <input type="checkbox"/> Paraprofessional <input type="checkbox"/> Other: _____		
2.	<input type="checkbox"/> Air Conditioning <input type="checkbox"/> Ambulation Assistance <input type="checkbox"/> Elevator Pass <input type="checkbox"/> Paraprofessional <input type="checkbox"/> Other: _____		
3.	<input type="checkbox"/> Air Conditioning <input type="checkbox"/> Ambulation Assistance <input type="checkbox"/> Elevator Pass <input type="checkbox"/> Paraprofessional <input type="checkbox"/> Other: _____		

*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:

Health Care Practitioner Information

Health Care Practitioner LAST NAME (Please Print)		FIRST NAME	Signature
Address		Tel. (____)____-____	Fax. (____)____-____
E-mail address*		Cell* (____)____-____	
NYS License # (Required) _____	Medicaid# _____	NPI # _____	Date ____/____/____

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To Completed by the Student's Health Care Practitioner

Allergies/Anaphylaxis
(note Available School-Specific Allergy Resources listed below)

List allergen(s): _____

Source of allergy documentation: Skin Testing Blood Test Parental Report
History of Anaphylaxis? Yes No

If yes, specify symptoms: Respiratory Skin GI Cardiovascular Neurologic

Medications _____

Was an **Allergy/Anaphylaxis MAF** completed? Yes No

Does the student have a history of developmental or cognitive delay? Yes No

If yes, specify diagnosis/diagnoses _____

Does the student have prior experience with self-monitoring? Yes No

- Can the student:
- Independently self-monitor and self-manage?
 - Recognize symptoms of an allergic reaction?
 - Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?
 - Follow safety measures established by a parent/guardian and/or school team?
 - Understand not to trade or share foods with anyone?
 - Understand not to eat any food item that has not come from or been approved by a parent/guardian?
 - Wash hands before and after eating?
 - Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?
 - Carry an epinephrine auto-injector?

Provider Signature _____

Diabetes

When was the student diagnosed with diabetes? ____/____/____

Are current DMAF orders on file at school for this student? Yes No

Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? If yes, please specify: Yes No

Can the student identify symptoms of hypoglycemia? Yes No

Can the student notify an adult when they feel that their blood glucose is not normal? Yes No

What is the plan to transition the student to independent functioning? _____

Provider Signature: _____

Seizure Disorder

Type of Seizure _____

Frequency of Seizures _____

Medication(s), including emergency medications _____

Are the seizures well-controlled by the current medication regimen? Yes No

Does the student require routine or prn emergency medication in school? Yes No

If yes, has an MAF been completed? Yes No

Other Associated Symptoms, including medication side effects _____

Number of seizure-related ER visits during the past year _____

Number of seizure-related hospitalizations/ICU admissions _____

Frequency of office visits/monitoring _____ weeks months

Last Office Visit ____/____/____

Activity Restrictions _____

Provider Signature _____

School Use Only

Available School-Specific Allergy Resources

- Allergy Table(s) in the lunchroom: _____ staff members for supervision
- Allergy Table(s) in the classroom: _____ staff members for supervision
- General Staff Training for Epinephrine administration: _____ staff members trained
- Student-Specific Training for Epinephrine administration: _____ staff members trained
- Allergy Response Plan
- Other: _____

Name of Principal or Principal's Designee: _____