

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 below.		
	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: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Not changed <input type="checkbox"/> Regressed <input type="checkbox"/> Other-explain	With treatment, does the child have PHYSICAL Functional Limitations? <input type="checkbox"/> Yes, If Yes, explain: <input type="checkbox"/> No <hr/> With treatment, does the child have MENTAL/EMOTIONAL Functional Limitations? <input type="checkbox"/> Yes, If Yes, explain: <input type="checkbox"/> No

Patient/Student's Name:

School:

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

Complete only the sections appropriate			
Recommended Evaluation(s) & Service(s)	Reason for recommendation:		
	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Evaluation recommendations: <ul style="list-style-type: none"> <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Deaf-blindness <input type="checkbox"/> Deafness or other hearing impairments <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Mental retardation <input type="checkbox"/> Orthopedic impairments <input type="checkbox"/> Specific learning disabilities <input type="checkbox"/> Speech or language impairment <input type="checkbox"/> Traumatic brain injuries <input type="checkbox"/> Visual impairment <input type="checkbox"/> Specific learning disabilities <input type="checkbox"/> Other Health Impairments, including chronic or acute health conditions. Explain: Comments: </td> <td style="width: 50%; vertical-align: top;"> School services recommendations (please check category and provide detail if applicable): <ul style="list-style-type: none"> <input type="checkbox"/> Dietary accommodations <input type="checkbox"/> Personal care <input type="checkbox"/> Psychological services <input type="checkbox"/> Medical procedures: <input type="checkbox"/> Speech, vision, and/or hearing therapy consult <input type="checkbox"/> Physical/occupational therapy consult <input type="checkbox"/> Specially designed instruction <input type="checkbox"/> Other – please explain: Comments: </td> </tr> </table>	Evaluation recommendations: <ul style="list-style-type: none"> <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Deaf-blindness <input type="checkbox"/> Deafness or other hearing impairments <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Mental retardation <input type="checkbox"/> Orthopedic impairments <input type="checkbox"/> Specific learning disabilities <input type="checkbox"/> Speech or language impairment <input type="checkbox"/> Traumatic brain injuries <input type="checkbox"/> Visual impairment <input type="checkbox"/> Specific learning disabilities <input type="checkbox"/> Other Health Impairments, including chronic or acute health conditions. Explain: Comments:	School services recommendations (please check category and provide detail if applicable): <ul style="list-style-type: none"> <input type="checkbox"/> Dietary accommodations <input type="checkbox"/> Personal care <input type="checkbox"/> Psychological services <input type="checkbox"/> Medical procedures: <input type="checkbox"/> Speech, vision, and/or hearing therapy consult <input type="checkbox"/> Physical/occupational therapy consult <input type="checkbox"/> Specially designed instruction <input type="checkbox"/> Other – please explain: Comments:
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	Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations, etc.)		
Other concerns not previously addressed:			
Medical Provider Signature	Date		