Request for Medical Accommodations to be Completed By Treating Physician

Physician Instructions: Please complete this form and return it to your patient's parent or fax to patient's school at _____.
If you have questions, please contact _____.

_____ is under my care for _____.
(Student' s Name) (Diagnosis)

What limitations does this diagnosis cause? (e.g. severely limits ambulation)

_____

_____

_____

How does this limitation affect the student's ability to attend and participate in class?
(e.g. requires constant medical attention)

_____

_____

_____

How does this limitation affect the student's ability to take transportation?
(e.g. increases risk for fractures)

_____

_____

_____

Expected duration of the limitation _____

Please provide any recommendations to accommodate the student's needs in the classroom and/or during school transportation (please attach additional sheets as needed):

_____

_____

_____

I request transportation accommodations to be provided for _____ weeks

I can be reached at: Tel#_____ and/or Beeper _____on:
Mon_____ (hrs) Tue_____ (hrs) Wed_____ (hrs) Thu_____ (hrs) Fri_____ (hrs)

Provider's Original Signature_____ License #_____

Print Name / Degree

_____ Date_____