Fulton County Schools
Section 504
MEDICAL FORM

School_____

Date Requested _____

STUDENT: _____ **DOB:** ____/____/____ **DATE:** ____/____/___

SCHOOL: _____ **TEACHER:** _____
(Referring Teacher/Agency)

ADDRESS: _____ **TELEPHONE:** _____

MEDICAL INFORMATION (To be completed by licensed physician)

Diagnosis: _____

Prognosis: _____

Medication and Dosage: _____

Special health care procedures, diet or activity restrictions: _____

SURGERY	Type of Surgery	Date	Results
	_____	____/____/____	_____
	_____	____/____/____	_____

MEDICAL IMPLICATIONS FOR INSTRUCTION: (To be completed by licensed physician)

Please indicate how the medical condition causes reduced efficiency in the student's school participation/performance in the following areas: (Include other areas as needed)

Attendance_____

Attention _____

Physical
Function/Ambulation _____

Daily Living
Activities _____

Academic
Limitations _____

School
Participation _____

Communication
Abilities_____

Other
Comments_____

PLEASE ATTACH COPY OF APPROPRIATE MEDICAL RECORDS. Thank you.

PHYSICIAN'S NAME _____ PHYSICIAN'S SIGNATURE _____

Address _____TELEPHONE _____ DATE ____/____/____