North Central Ohio Educational Service Center

North Central Ohio ESC, Tiffin Campus
928 W. Market St., Suite A
Tiffin, OH 44883
Phone: 419-447-2927
Fax: 419-447-2825

North Central Ohio ESC, Marion Campus
333 E.Center Street
Marion, OH 43302
Phone: 740-387-6625
Fax: 740-383-4804

Medical Information Form

Doctor: _____ **Date: _____**

Student: _____ **D.O.B: _____**

We are evaluating the above student for eligibility as a child with a disability. It has come to our attention that the above student has some medical concerns that may or may not impact his/her ability to learn. To be considered a child with a disability this is defined by the 2008 Operating Standards for Ohio Educational Agencies serving Children with Disabilities as:

> "3301-51-01(B)(10)"Child with a disability" means a child evaluated in accordance with rule 3301-51-06 of the Administrative Code as having a cognitive disability (mental retardation), a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional impairment (referred to in this rule as "emotional disturbance"), an orthopedic impairment, autism, traumatic brain injury, and other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.

The rules require the participation of a physician in some of the areas listed above in the decision on whether or not a child is eligible for special education services. Please complete the attached form and return it either by fax or mail to the address listed above as soon as possible.

Thank you for your help in this process.

Name: _____ **Position:** _____

School District: _____

Medical Information Form

Student: _____

Date Last Seen in the Office: _____

Medical Diagnosis/Physical Impairment (Please List All):_____

_____

This impairment may adversely affect this student's educational performance. ___True ___False

Current Medications: _____

Accommodations the student may need in school: _____

_____

Restrictions, if any: _____

_____

Physical Adaptations, if any: _____

_____

Other Comments: _____

_____

_____

Physician's Name Printed: _____

Physician's Signature: _____ **Date:** _____

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MEDICAL INFORMATION FORM

Identifying Data Date: _____

Child's Name: _____ DOB: _____

Parent's Name: _____ Address: _____

I. General physical health:

Height _____ Weight _____ BP _____ Skin _____ Head _____
Eyes _____ Ears _____ Nose _____ Teeth _____ Neck _____
Chest _____ Extremities _____

Vision: Speech and hearing:

II. General neurological findings, if applicable:

Gait _____ Station _____ Muscle Power _____
Muscle Tone _____ Reflexes _____ Cranial Nerves _____

Motor abnormalities: Gross Motor Coordination: Fine Motor Coordination:

Sensory abnormalities:

III. Behavioral Problems (check if observed or reported by informant)

☐ Hyperactive ☐ Withdrawn ☐ Short Attention Span ☐ Disturbed sleep pattern ☐ Distracted ☐ Other (please describe) _____

IV. Medical and emotional diagnosis, treatment, medications, and psychological/ Counseling notes. Recommendations (include medication as prescribed):

_____ _____
Physician's Signature Date

_____
Physician's Printed Name

_____
Address

_____
Telephone Number