Kentucky Public School District Health Care Provider Questionnaire Regarding Section 504 Eligibility

District Name:

Student's Name:

Date of Birth:

1. Detail available relevant medical background, including a written diagnostic statement with the current ICD Medical Diagnosis and Code or current DSM Diagnosis and Code and copies of any/all relevant reports.

2. Does the student need a health service accommodation to prevent a life threatening or serious health reaction/situation in the school environment? If so, list what precautions are recommended for consideration at an upcoming 504 meeting.

Please attach any reports pertinent to the serious health needs of this child in the school setting.

By: (Health Care Provider)

Date:

Heath Care Provider Address:

Please forward this completed form to:

Name:

Address: