Medical Certification Form

To Be Completed by the Student's Physician

HAND CARRIED COPIES WILL NOT BE ACCEPTED

Patient's Name: ___________________________________

Today's Date: _________________________

1) Please state the complete diagnosis:

____

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2) How did you arrive at your diagnosis? Please check all relevant items below; adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student:

Structured or Unstructured interviews	☐	Medical tests	☐
Interviews with other persons	☐	Medical History	☐
Behavioral Observations	☐	Developmental History	☐

3) Date of Diagnosis: _______________________________

4) This student has been under a physician's care for this issue since: ______________________

5) Date student was last seen: ______________________________

6) How long is this condition likely to persist _____________________________________

7) How often is the student required to check-in with a physician?

Once a week   Once a month   Every three-four months   Every six months

Once a year   As needed   Other: ___________________________

8) What medications is the student currently taking?

NAME: ______________________ AMOUNT: _____________ TIMES PER DAY: _____________

NAME: ______________________ AMOUNT: _____________ TIMES PER DAY: _____________

NAME: ______________________ AMOUNT: _____________ TIMES PER DAY: _____________

9) How effective is the medication? How might side-effects, if any, affect the student's academic performance?

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10) Please check which of the major life activities listed below are affected because of the medical diagnosis. Please indicate the level of limitation.

	NO IMPACT	MODERATE IMPACT	SUBSTANTIAL IMPACT	DON'T KNOW
Concentrating	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self-care	☐	☐	☐	☐
Waiting/Standing	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Timely submission of assignments	☐	☐	☐	☐
Attending class regularly and on-time	☐	☐	☐	☐
Making and keeping appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Organization	☐	☐	☐	☐

11) What other specific symptoms manifesting themselves at this time might affect the student's academic performance?

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12) What is the student's prognosis? How long do you anticipate that the student's academic achievement will be impacted by his/her disability?

Circle one: 6 months 1 year 1-2 years on-going permanently unknown

13) Is there anything else you think we should know about the student's medical condition?

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Name/Title ____

Signature ____

License/Certification # ______________________________ State ________________

Address ____

City, State, Zip Code ____

Phone ____________________________

Please Fax or Mail To:

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