

# CAMPBELL COUNTY SCHOOL DISTRICT PHYSICIAN QUESTIONNAIRE FOR MEDICAL CONCERNS

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

1. Detail available medical background, including a written diagnostic statement with the ICD9 Medical Diagnosis and Code or the DSM IV Diagnosis and Code and copies of any/all reports.
  
  
  
  
  
  
  
  
  
  
2. In your opinion, do these impairments “substantially limit” this student’s ability (with medication and in comparison to the average peer) to access, receive, and benefit from learning or school activities? If yes, how?
  
  
  
  
  
  
  
  
  
  
3. Please list any recommendations for consideration at an upcoming conference.

Please attach any reports pertinent to the medical/educational needs of this child.

Signature of Health Professional

Date

Please forward this copy to/or fax to:     Marlene Jones or Sam Jones  
Special Education Department  
Campbell County Schools  
51 Orchard Lane  
Alexandria, KY 41001  
Phone: (859)635-2173 Fax: (859) 448-2794

Parent Consent for release of records \_\_\_\_\_ Date \_\_\_\_\_

Parent Consent to discuss/share information \_\_\_\_\_ Date \_\_\_\_\_