ONSLOW COUNTY SCHOOLS
Section 504/ADA
MEDICAL EVALUATION FORM

THIS FORM IS TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

I. Student Data

Student Name: ____ DOB: ____________

School: ____ Date: ____________

II. Medical Evaluation/History

1. List all medical conditions or health problems for which the student is currently receiving medical care:
   ____

2. Does the student currently take medication on a regular basis? ____YES ____ NO
   Name of medication(s): ____
   Medication prescribed for: ____
   Side effects of medication: ____
   Side effects that may substantially limit one or more major life functions: ___________________
   ____

3. Does the student have any severe allergies or drug sensitivities (e.g. food, insect stings, pollens, medicines) ____ YES ____ NO
   List the allergies/severe sensitivities: ____
   Describe allergic reaction: ____

4. Has the student been diagnosed with ADD or ADHD? ____YES ____ NO
   Date of diagnosis: ______________ Treatment prescribed: ______________________________
   Has treatment been effective? ____YES ____NO Explain:_____________________________
   ____

5. Would this health problem be expected to cause and/or effect the student to be unable to successfully complete academic or developmental task or other major life functions within the educational environment? ____ YES ____ NO
   Explain: ____

6. Would this health problem cause the student to experience the inability to attend school regularly and/or for a full school day? ____YES ____ NO
   Explain limitations: ____
   ____

7. Describe any limitations to physical activity which may result from the health problem:
   ____

8. Describe how this health problem may cause a substantial limitation to one or more major life functions:
   ____

9. Based on your knowledge of this student, is there anything in the student's birth and/or developmental history that could substantially limit one or more major life functions within the educational environment? ____ YES ____ NO

____ ______________________

Physician's Signature Date

Address of medical practice: ____