

Physician's Statement

(504 Eligibility)



To: _____,
(Physician's Name)

The School District of Lee County seeks information from you for the purpose of educational planning for the student referenced below. Your assistance in completing this form is appreciated. Please return the form to the parent and/or the student's school.

Student's Name: _____ Sex: ____ Date of Birth: _____

Parent(s): _____

School: _____

Nature, extent, and duration of any physical/health/medical condition(s) that school personnel should be aware of: _____

Onset Date of Condition(s): _____ Prognosis: _____

Prescribed Medication(s)/Dosage(s), if any: _____

How does/do the above-referenced condition(s) impact the student's major life activities, if at all? _____

Physician's Signature

Date