# Medical Home↔School - Evaluation/Services Form

This form will serve as communication between the student's health care provider and school professionals as it relates to health concerns that may impact the student's education.

| Contact information | | | |
|---|---|---|---|
| | Patient/Student's Full Name: | Parent/Guardian's Name: | Phone Number: |
| | Patient/Student's School & District: | Principal's Name (if known): | School Phone No.: |
| | ❑ I, the undersigned, have authorized sharing of information by signing a Medical Home-School Information Release that is current and will remain in effect until the date indicated here: _____.<br><br>Parent/Guardian's Signature: Date: | | |

| Physician Contact Info | | | |
|---|---|---|---|
| | Medical Home Provider (MD, DO, PA, NP): | Phone Number: | Fax Number: |
| | Mailing Address: | E-mail address: | |
| | If not the above, who is the best contact person: | Phone Number: | |
| | Mailing Address: | E-mail address: | |
| | Preferred Method and Time for Contact: | | |

| Diagnosis and Treatment | | |
|---|---|---|
| | Student's condition/diagnosis:<br><br>Date of onset: | |
| | Nature of current treatment/medication, if any:<br><br>Side effects from treatment/medication (indicate current, expected, or possible, particularly as they may impact the classroom): | |
| | With this treatment the patient has:<br><br>❑ Recovered<br>❑ Improved<br>❑ Not changed<br>❑ Regressed<br>❑ Other-explain | With treatment, does the child have PHYSICAL Functional Limitations?<br>❑ Yes, If Yes, explain:<br>❑ No<br><br>With treatment, does the child have MENTAL/EMOTIONAL Functional Limitations?<br>❑ Yes, If Yes, explain:<br>❑ No |

Complete other side (page 2) of this form also

**Patient/Student's Name:** **School:**

| Areas Affected by the Condition | | | |
|---|---|---|---|
| **Life Activities** possibly affected: | **School Activities** possibly affected by this condition: | | |
| ❑ Caring for oneself<br>❑ Performing manual tasks<br>❑ Walking<br>❑ Seeing<br>❑ Hearing<br>❑ Speaking<br>❑ Breathing<br>❑ Learning<br>❑ Working | ❑ School attendance<br>❑ Memory/attention<br>❑ Thirst/appetite<br>❑ Mobility/motor skills<br>❑ Peer interactions<br>❑ Personality<br>❑ Toileting/hygiene<br>❑ Stamina/fatigue<br>❑ Meals/feeding/foods<br>❑ Transportation | ❑ Academic testing<br>❑ Physical education<br>❑ Field trips/events<br>❑ Playground/recess<br>❑ Oral expression<br>❑ Articulation<br>❑ Written expression<br>❑ Comprehension<br>❑ Transitions<br>❑ Other: | |
| Explain: | Explain: | | |

**Complete only the sections appropriate**

NOTE: The following information will be considered by school teams to determine steps to be taken such as evaluation, services, accommodations or other considerations.

**Recommended Evaluation(s) & Service(s)**

Reason for recommendation:

**Evaluation recommendations:**

- ❑ Autism
- ❑ Deafblindness
- ❑ Developmental Delay
- ❑ Emotional Disturbance
- ❑ Hearing Impairments/Deafness
- ❑ Intellectual Disability
- ❑ Multiple Disabilities
- ❑ Orthopedic Impairments
- ❑ Other Health Impairments
- ❑ Specific Learning Disabilities
- ❑ Speech/Language Impairment
- ❑ Traumatic Brain Injury
- ❑ Visual Impairment (Including Blindness)

Comments:

**School services recommendations**
(please check category and provide detail if applicable):

- ❑ Dietary accommodations
- ❑ Personal care
- ❑ Psychological services
- ❑ Medical procedures:
- ❑ Speech, vision, and/or hearing therapy consult
- ❑ Physical/occupational therapy consult
- ❑ Specially designed instruction
- ❑ Other – please explain:

Comments:

Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations, etc.)

Other concerns not previously addressed:

| Medical Provider Signature | Date |
|---|---|
| | |

For information about Medical Home, visit http://www.medhomeportal.org/ Revised 10/13/2008