MEDICAL ACCOMMODATIONS REQUEST FORM

Office of School Health | School Year 2019-20

This form should be submitted along with all relevant forms to this request. Please attach additional documentation, if needed.

Student Name:	OSIS #: _ _ _ _ _ _ _ _ _	Student's Date of Birth: ____/____/_____

☐ 504 Request ☐ IEP Request: IEP Classification: _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

MEDICAL INTERVENTION

Medical Diagnosis _____/ICD-10 Code/DSM-V Code(s): _____.___ _____.___ _____.___

Expected duration of accommodation: _____ weeks This condition is: ☐ Acute ☐ Chronic

Student's current clinical status *(level of control, current management plan, pending evaluations, etc.)*:

Type of Medical Intervention:	Time of Intervention:
☐ Administration of Emergency Medications *(e.g. glucagon, rectal diazepam)* Please list all emergency medications: *Please attach all relevant Medication Administration Forms (MAFs)*	☐ during school ☐ during transport
☐ Procedures *(e.g., suctioning, airway management, vagal nerve stimulator) Please complete the Request for Provision of Medically Prescribed Treatment Form* Please list all procedures:	☐ during school ☐ during transport
☐ Equipment Management *(e.g. ventilator, oxygen) Please complete the Request for Provision of Medically Prescribed Treatment Form* Please list all equipment that will accompany the student during school and/or transport:	☐ during school ☐ during transport
☐ Other *Please complete all appropriate forms (MAFs, Request for Provision of Medically Prescribed Treatment Form)* Please list:	☐ during school ☐ during transport

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STUDENT CONSIDERATIONS

Supervision Required: ☐ during school ☐ during transport
If yes, please document the reason for additional supervision, and the specific tasks/responsibilities that should be performed to support the student during the school day and/or during transport.

Is the student considered medically unstable? *(at risk for medical decompensation during school or during transport)*	☐ No ☐ Yes *(please describe):*
Is the student considered behaviorally unstable? *(poses a danger to himself or to other students)*	☐ No ☐ Yes *(please describe):*
Does the student currently utilize the following:	☐ Crutches ☐ Cast ☐ Wheelchair ☐ Other:

Please list any other clinical concerns relevant to supporting the student during the school day and/or during transport (Attach additional information if needed):

CONTACT INFORMATION & ATTESTATION

Phone number:	Office: _ _ _ - _ _ _ - _ _ _ _		Cell: _ _ _ - _ _ _ - _ _ _ _	Email:	
Best days to be reached:	☐ Mon: Time:_____	☐ Tues: Time:_____	☐ Wed: Time:_____	☐ Thurs Time:_____	☐ Fri: Time:_____

I attest that I have provided clinical services to this student and that the information above is complete and clinically accurate as of the date provided below.

Provider's Name (print):	License #: _____
Provider's Signature:	Date of completion: _ _ /_ _ /_ _ _ _