SUWANNEE COUNTY SCHOOL DISTRICT

Office of Student Services
1740 Ohio Avenue South, Live Oak, Florida 32064

Physician's Statement

The Suwannee County School District seeks information from you for the purpose of education planning. The student has been referred by his/her teacher/parent due to difficulties in school. Please complete the sections below to assist us in determining eligibility and in providing appropriate educational services for this student. Please complete the form, sign, and return to the address or fax number below. This form must be signed by a **Medical Doctor**.

School: _____ **School Contact:** _____

School Address: _____ **Phone:** _____

_____ **Fax #:** _____

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

1) What is the student's medical diagnosis? *(Please include a description of the impairment)*

2) I have prescribed the following medication(s) to treat symptoms of this medical condition:

3) Date of last physical examination:

4) How might the diagnosis(es) impact the student's learning in the educational environment?

- ☐ Difficulty Following Directions
- ☐ Disorganized
- ☐ Distractible
- ☐ Easily Frustrated
- ☐ Focus
- ☐ Frequent Absences
- ☐ Heightened Alertness
- ☐ Hyperactive
- ☐ Hypoactive
- ☐ Impulsive/Excitable
- ☐ Limited Alertness/Attention
- ☐ Limited Concentration
- ☐ Limited Strength
- ☐ Tires Easily
- ☐ Limited Ability to Move, Sit, or Manipulate Materials in the Learning Environment.
- ☐ Other: _____

Physician's Printed Name: _____ **Date Signed:** _____

Physician's Signature: _____ **Office Number:** _____

Physician's Mailing Address: _____