

**ORLEANS PARISH SCHOOL BOARD**  
**STUDENT EVALUATION AND SUPPORT SERVICES**

*3520 General DeGaulle Drive*  
*New Orleans, Louisiana 70114*  
*Phone: 304-4988 Fax: 309-4158*

Medical information is needed for the following student in order to determine if there are **HEALTH IMPAIRMENTS** sufficient to warrant special education services. Please check appropriate behaviors and provide a simple explanation when indicated:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Parent(s): \_\_\_\_\_

Address: \_\_\_\_\_

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Diagnosis: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Severity of illness:  **mild**     **moderate**     **severe**

Condition causes  **reduced efficiency in school work because of**  
 **temporary or chronic lack of strength**  
 **temporary or chronic lack of vitality**  
 **temporary lack of alertness**

Student is substantially limited in the following major life activity/activities:

<input type="checkbox"/> <b>caring for one's self</b>	<input type="checkbox"/> <b>seeing</b>	<input type="checkbox"/> <b>working</b>
<input type="checkbox"/> <b>performing manual tasks</b>	<input type="checkbox"/> <b>hearing</b>	<input type="checkbox"/> <b>walking</b>
<input type="checkbox"/> <b>breathing</b>	<input type="checkbox"/> <b>speaking</b>	<input type="checkbox"/> <b>learning</b>

Other major life activity: \_\_\_\_\_

This condition significantly interferes with educational performance in the following way(s): \_\_\_\_\_

Student may need:  **Adapted Physical Education**     **OT**     **PT**     **Speech**

Specify the medical implications for instruction and for physical education:

\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return to:**

\_\_\_\_\_  
**Evaluation Coordinator**  
**Exceptional Children's Services**