Cherokee County School District

SECTION 504 GENERAL MEDICAL REPORT

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

TO BE COMPLETED BY PHYSICIAN or PRIVATE PSYCHOLOGIST

Diagnosis/Medical History: _____

_____

_____

Current Medication (if any)/Notable Side Effects: _____

_____

_____

This condition / impairment substantially limits the following major life activities:

- ☐ Caring for oneself
- ☐ Performing Manual Tasks
- ☐ Seeing
- ☐ Hearing
- ☐ Eating
- ☐ Sleeping
- ☐ Walking
- ☐ Standing
- ☐ Lifting
- ☐ Bending
- ☐ Speaking
- ☐ Breathing
- ☐ Learning
- ☐ Reading
- ☐ Concentrating
- ☐ Thinking
- ☐ Communicating
- ☐ Major Bodily Function
- ☐ Working
- ☐ Other: _____

Additional information on this student's diagnosis/ condition and how it impacts the student within the school environment: _____

_____

_____

Please describe any physical health care or emergency procedures, if applicable. _____

_____

_____

_____

Cherokee County Section 504 General Medical Examination Report

Student's Name: _____ **Date of Birth:** _____

Surgeries:

Type of Surgery	Date	Results

Hospitalizations:

Hospital	Date	Results

Prognosis/precautions _____

_____

Is student under the care of another physician or medical agency? ☐ Yes ☐ No

If yes, please specify _____

_____

_____ _____

(Doctor of Medicine's Signature) **(Psychologist's Signature)**

_____ _____

Physician's Name **(Print)** **Psychologist's Name (Print)**

_____ _____

Address Address

_____ _____

Address Address

_____ _____

Address Address

_____ _____

Date Date

Return to: _____

_____

_____

_____

Date Received at the School: _____