Appendix C. Medical Opinion Form

The Michigan Administrative Rules for Special Education require a physician as a participant in the multidisciplinary evaluation process for the team determination of "Other health impairment". While this form is not required, it is necessary to have the physician's name, area of specialty, and the student's medical diagnosis.

Please complete the following in order to help determine eligibility for special education services and return to the school office listed below.

School Name: ___________________________________      Date Requested:  _________________
Special Ed. Contact: ____________________________                        Phone Number:  __________________
School Address:   __________________________________                     Fax number:  _____________________
City, State, Zip:  __________________________________

________________________________________________________________________

Physician’s Name:  ______________________________  Phone Number: _____________________
Practice Name:  ________________________________                         Fax Number:  _______________________
Practice Address:_______________________________
City, State, Zip:  ________________________________

_____________________________________________________________________________________________

Student:  ____________________________ Date of Birth:  ________________ Parent(s):
Home address:   __________________________________ City, State, Zip:  __________________________

Please indicate this student’s diagnosed health problem:

□ Asthma       □ Lead Poisoning
□ Attention deficit disorder □ Leukemia
□ Attention deficit hyperactivity disorder □ Nephritis
□ Diabetes □ Rheumatic fever
□ Epilepsy □ Sickle cell anemia
□ A heart condition □ Other:
□ Hemophilia

ICD-10 Code:  ________________________________

I consider this health problem to be:  □ Chronic □ Acute       Is this a lifelong medical condition?  □ Yes □ No
Physician’s Comments:  ________________________________________________

________________________________________________________________________________________

Physician’s Signature  ___________________________________ Date  _______________________

□ An orthopedic surgeon       □ An internist
□ A neurologist       □ A pediatrician
□ A family physician        □ A psychiatrist
□ A physician’s assistant    □ Other: