HIGHLINE
PUBLIC SCHOOLS

Health Concern Verification for 504 Accommodations at School

Date: _____ Student's Name: _____

Birthdate: _____

Dear _____,

In order to provide appropriate accommodations for a student who may need a 504 plan for a disability while in school we need the medical documentation from you. This information will confirm the existence of a handicapping condition and the way in which it may affect the child's education. The educational team will determine if this condition substantially limits a major life activity and if so which accommodations are needed. Please complete and send to:

_____	_____	_____
Staff Contact	School Address	Fax

Thank you for your help. For any questions call me at _____

Sincerely,

****

Diagnosis:

_____

Educational Implications:

_____

_____

_____	_____	_____
Signature of Health Care Provider	Name (PRINT)	Date

Telephone: _____ Fax: _____