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|---|-------------------|-------------------|
| <input type="checkbox"/> Clarkes Elementary School    | Ph (503) 632-2390 | Fx (503) 632-5212 |
| <input type="checkbox"/> Molalla Elementary School    | Ph (503) 829-4333 | Fx (503) 829-2614 |
| <input type="checkbox"/> Molalla High School          | Ph (503) 829-2355 | Fx (503) 829-6382 |
| <input type="checkbox"/> Molalla River Middle School  | Ph (503) 829-6133 | Fx (503) 829-5680 |
| <input type="checkbox"/> Mulino Elementary School     | Ph (503) 829-6888 | Fx (503) 829-2037 |
| <input type="checkbox"/> Rural Dell Elementary School | Ph (503) 651-2128 | Fx (503) 655-2127 |

**MEDICAL STATEMENT OR HEALTH ASSESSMENT**

Please return by: \_\_\_\_\_ ATTN: \_\_\_\_\_

This child has been referred to determine special education eligibility or special accommodations related to a medical diagnosis. Oregon law requires that a medical statement or health assessment is obtained for some disabilities. This information is **urgently needed** to determine appropriate services for this child in order to comply with federal guidelines and special education services or accommodations. Please answer all of the questions with appropriately checked boxes and sign below

<b>Student</b>		<b>DOB</b>	
<b>Does this child have a visual impairment?</b>		<input type="checkbox"/> No <input type="checkbox"/> Yes (please complete this box)	
This child's <input type="checkbox"/> acuity is 20/70 or less with correction or <input type="checkbox"/> vision field is restricted to $\leq 20^\circ$ in better eye. This child <input type="checkbox"/> has an eye pathology /progressive eye disease that is expected reduce residual acuity or visual field to one of the previously listed. <input type="checkbox"/> Assessment results are inconclusive and child has demonstrated inadequate use of residual vision			
<b>Does this child have a hearing impairment?</b>		<input type="checkbox"/> No <input type="checkbox"/> Yes (please complete this box)	
This child has: <input type="checkbox"/> Sensory hearing loss <input type="checkbox"/> Conductive hearing loss which <input type="checkbox"/> is treatable <input type="checkbox"/> is NOT treatable <input type="checkbox"/> with the use of amplification			
<b>Does this child have a voice disorder or relevant medical issues that contribute to speech/language problems?</b>			
<input type="checkbox"/> No <input type="checkbox"/> Yes (please specify):			
<b>Does this child have an impairment that is expected to last more than 60 calendar days or has this child been diagnosed with other physical, medical, sensory, mental health conditions or is this child taking medications that may affect his or her educational performance? <input type="checkbox"/> No <input type="checkbox"/> Yes (please check next to all applicable areas and specify as requested)</b>			
<input type="checkbox"/> Autism Spectrum Disorder		<input type="checkbox"/> Cognitive Impairment: _____	
<input type="checkbox"/> Orthopedic Impairment		<input type="checkbox"/> Motor Impairment: _____	
<input type="checkbox"/> Traumatic Brain Injury		<input type="checkbox"/> Other Health Impairment: _____	
<input type="checkbox"/> Seizure Disorder		<input type="checkbox"/> Medication: _____	
<b>Does this child have any activity restrictions?</b> <input type="checkbox"/> No <input type="checkbox"/> No contact sports <input type="checkbox"/> No swimming <input type="checkbox"/> No elevated heights			
<input type="checkbox"/> No regular recess or PE <input type="checkbox"/> Other: _____			
<b>Additional notes regarding diagnosis or impairment:</b>			