Cannon County Schools
Section 504
Physician Questionnaire for Medical Concerns

Student Name: _____ DOB: _____

Address:_____

Parent Names:_____ Phone:_____

1. **Detail available medical background, including a written diagnostic statement and copies of any/all reports.**

2. **In your opinion, how do these difficulties "substantially limit" this student's ability to receive and benefit from learning?**

3. **Recommendations for consideration at an upcoming conference:**

Please attach any reports pertinent to the medical/educational needs of this child.

Please forward this copy to _____

Thank you,