



530 Perryville St • Harrodsburg, KY 40330
(859) 733-7000 • Fax (859) 733-7004
www.mercer.kyschools.us

SECTION 504 HEALTH CARE PROVIDER QUESTIONNAIRE

Student Name

Date of Birth

Detail available relevant medical background, including a written statement with the student’s current medical, physical, or mental health impairments. **Please provide current ICD Medical Diagnosis and Code or current DSM-V Diagnosis and Code and copies of any/all relevant reports if possible.**

In your opinion, do these difficulties “substantially limit” this student’s ability to access, receive and benefit from learning or school activities? If yes, how?

Does the student need a health service accommodation to prevent a life threatening or serious health reaction/situation in the school environment? If so, list what precautions are recommended for consideration at an upcoming 504 meeting.

Recommendations for consideration in the development or revision of an accommodation plan.

This form was completed by:

Name

Title/Occupation

Signature

Phone

Date _____

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Please return this completed form to the student’s educational representative or the following:

504 Chairperson

Fax

Email



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