

Form JGC-8

*Empowering Dreams for the Future*

**MEDICAL EVALUATION REPORT**

This form is intended to provide to the Cobb County School District some of the medical information necessary to determine:

● a child’s eligibility as a child with a disability for special education services or Section 504 accommodations

● a child’s medically necessary nutritional needs/accommodations; and/or,

● any services to be provided or made available by school nursing staff. (For some students, more detailed doctors’ orders may

be necessary)

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| --- | --- | --- | --- | --- | --- |
| Name: |  | DOB: |  | School: |  |

|  |  |
| --- | --- |
| Date Last Seen: |  |

|  |  |
| --- | --- |
| Diagnosis: |  |

|  |  |
| --- | --- |
| Prognosis/Anticipated Duration: |  |

|  |
| --- |
| Anticipated Impact of Diagnosis on Student’s Educational Performance: |

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies: | 1. |  | Inhalation  Ingestion  Touch/exposure |

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2. |  | Inhalation  Ingestion  Touch/exposure |

|  |
| --- |
| Special Diet/Food Restrictions: |

|  |  |
| --- | --- |
| Food Substitutions: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Medications: |  |  |  |

Name Dosage Frequency

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

Name Dosage Frequency

|  |  |
| --- | --- |
| Special Health Care Procedures: |  |

|  |  |
| --- | --- |
| Activity Restrictions: |  |

|  |
| --- |
| Additional comments, suggestions or medically relevant information: |

|  |  |
| --- | --- |
| Doctor’s Name and Address (please print): |  |

This student is a patient who is under my care, and I certify that the above information is true and correct.

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Physician’s Signature & Georgia Board Certification Number Date Office Phone Number