CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

Please return to Bettye Liberty, ESP Director, bliberty@ocacrusaders.com

Ocala Christian Academy
Professional Medical Diagnosis Form

Student Name: _____

Grade: _____

Name of Medical Provider or Mental Health Provider:

_____

Address: _____

Phone: _____

Dear Medical Provider or Mental Health Provider:

It is our understanding that you either have already evaluated this student or will do so in the near future in order to determine the student's medical diagnosis. Below is authorization from this student's parent/legal guardian which will allow you to share information with us to assist in providing this student appropriate educational services. Please complete the questions below and attach additional information relevant to the diagnosis if necessary.

_____ _____

Signature of Parent/Legal Guardian authorizing release of medical information Date

Diagnosis*

- ☐ Does not meet criteria for ADHD
- ☐ ADHD Predominantly Inattentive subtype
- ☐ ADHD Predominantly Hyperactive/Impulsive subtype
- ☐ ADHD Combined subtype
- ☐ Anxiety or Depression
- ☐ Autism Spectrum Disorder
- ☐ Developmentally Delayed
- ☐ Oppositional-Defiant Disorder
- ☐ Other medical disorders_____

Describe source of evidence and diagnosis. _____

Describe how the symptoms which led to your diagnosis might adversely affect this student's educational performance and thus cause significant learning problems at school. _____

_____

☐ Yes ☐ No Behavior Ratings Scale and/or Behavior History was performed.

Date of most recent diagnosis: _____

*A multi-disciplinary team at the school will consider the information from your report along with data collected by the school and other sources in determining if the student meets the eligibility guidelines for any SP services, 504 services, or other special services from the school. A diagnosis of ADHD or Anxiety in and of itself is not sufficient to automatically qualify a student for any special school services.

Treatment Plan

- Medication: ☐ Yes ☐ No If yes, list type and dosage:_____
- Referrals to other specialists: ☐ Yes ☐ No If yes, list to whom and why:_____

Signature

_____ _____

Signature of Medical Provider or Mental Health Provider Date

_____

License # from State Board of Examiners