Rye Neck Union Free School District
Special Services Department
300 Hornidge Road
Mamaroneck, NY 10543
Tel: (914) 777-4860
Fax: (914) 777-4861

PHYSICIAN INPUT FORM

Student: ________________________________ **Date of Birth:** ______________________________

Physician: _______________________________ **Date of Last Exam:** ________________________

Diagnosis: ____

1. **Please describe in detail the physical and/or mental effects of the medical condition of the patient.**

2. **Please describe the basis for the determination of the disability.**

3. **Please indicate the medical and/or therapeutic treatment being provided for the above condition.**

4. **Do you consider this patient's condition to be a disability (a physical or mental impairment which substantially limits one or more life activities – i.e. caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working?) If yes, to what extent?**

5. **Please indicate any manifestation of the medical condition that could substantially limit this patient's educational achievement.**

6. **Please indicate any manifestations of the medical condition that could substantially limit this patient's school behavior.**

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Physician's Signature **Date**