Nikolaos C. Koutsogiannis
Superintendent of Schools

Frances C. Adler
Business Administrator

Date: _____

Dear Physician:

A request for a student-related 504 reasonable accommodation has been made by a parent/guardian for _____*(student name) who is in* _____*(Grade) at*_____ *(School).*

We are respectfully requesting your assistance with processing this request. To this end, please complete the following questions below and return to the parent/guardian.

1. *Does the student have a physical or mental impairment that will prevent them from learning or attending school?* _____*YES* ____*NO*

   If YES, what is the impairment?

   _____

   A. *Please indicate if the medical condition and/or disability is* _____*temporary or* _____*permanent?*

   B. *If this is temporary, how long will the student's health condition continue to limit their ability to learn?* ____ *# of Weeks* ____ *# of Months* ____ *N/A*

2. *What accommodations and/or adjustments do you feel might be effective in addressing the limitation and enabling the student to perform to the best of their ability?*

   _____

   _____

3. *How long will the student need the proposed reasonable accommodation?*

   _____

   _____

4. *Is the student on any medications that need to be administered during the school day?*
   _____ YES _____ NO
   If YES, what are they and how often? _____
   _____

5. *To what extent is the student able to self-monitor their condition? If the student needs nurse/staff assistance, what is the staff member/nurse supposed to do?* _____
   _____
   _____

6. *Does the student require any special equipment during the school day? If so, are there any special handling instructions or issues the school needs to be aware of?* _____
   _____
   _____

7. *Please provide any additional comments or suggestions:* _____
   _____
   _____

Thank you,

Nikolaos C. Koutsogiannis
Superintendent of Schools

_____ _____
Physician Name (Please Print) *Date*

_____
Physician Signature

Practice Name: _____
Address: _____
Phone Number: _____