

CLARK COUNTY SCHOOLS
MEDICAL EVALUATION FOR SPECIALLY DESIGNED INSTRUCTION
ELIGIBILITY DETERMINATION

Student's Name: _____ DOB: _____
School: _____ Grade: _____ Date: _____

The above referenced student is currently being evaluated to determine the most appropriate educational placement and the need for specially designed instruction. As the diagnosing or monitoring qualified professional for this student, please complete all the information requested below.

1. Current diagnosis and symptomology the student demonstrates: _____

2. Which specific area does the diagnosis affect and how:
Vitality: ☐ _____

Strength: ☐ _____

Alertness: ☐ _____

3. What adverse effect on educational performance does this diagnosis have on the student's performance at school: _____

4. Specific academic recommendations: _____

Physician's Signature: _____

Physician's Printed Name: _____

Office Name: _____ Office Phone Number: _____

Office Address: _____

Date of Evaluation: _____ Date of Report: _____