

ALBEMARLE COUNTY PUBLIC SCHOOLS  
 DEPARTMENT OF SPECIAL SERVICES  
 401 McINTIRE ROAD  
 CHARLOTTESVILLE, VIRGINIA 22902  
 (434) 296-5885

**MEDICAL EVALUATION FOR SPECIAL EDUCATION SERVICES**

**Dear Physician:**

**This evaluation is for determination of eligibility for special education.**

**Please complete and return this form to the child's school promptly. For more information, contact (school official) \_\_\_\_\_ at (Telephone number) \_\_\_\_\_ .**

Student: \_\_\_\_\_ Last First Middle DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

School: \_\_\_\_\_

School Address: \_\_\_\_\_

Areas of Concern: \_\_\_\_\_

Examining Physician (Please Print) \_\_\_\_\_

Physician's Address \_\_\_\_\_ Telephone \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure \_\_\_\_\_

<b>Systems Examination</b>	<b>Normal</b>	<b>Abnormal</b>		<b>Normal</b>	<b>Abnormal</b>
General appearance, nutrition			Neck		
Posture, Gait			Heart		
Skin			Lungs		
Eyes: External			Abdomen		
Eyes: Fundi			Bones/Joints/ Muscles		
Nose			Neurological		
Teeth			Developmental Screening		
Throat			Other		
Ear: External Canal			Behavior During Exam		
Ear: Tympanic Membrane					

If your examination of this student was normal, please check. \_\_\_\_\_

1. Did you personally observe evidence of any of the following conditions which might interfere with school performance? (Check where appropriate)
- Neurological deficit or seizure disorder.
  - Developmental delay (for children 5 years of age or younger).
  - Behavior disorder.

Please explain if any of the above is checked:

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2. Did you find or infer any underlying chronic illness or physical problem which might (please check where appropriate: physical education classes).
- cause the student to have limited strength or vitality?
  - interfere with this student's participation in sports or physical education classes?
  - cause this student to be absent from school frequently or periodically?

If any of the preceding items has been checked, and not already discussed, please explain:

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3. Is physical therapy indicated?  YES  NO **If yes, attach prescription.**

4. Are there any medications which this student may require?

5. Will further evaluation or treatment related to school performance be required in your clinic?  
 YES  NO

6. Will further evaluation related to school performance be required in a specialty clinic? (Appointment to specialty clinic cannot be made without consent of parent. Parent must accompany patient to specialty clinic).  
 YES  NO

Date of Future Appointment: \_\_\_\_\_

Please explain:

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\_\_\_\_\_  
Signature of Examining Physician

\_\_\_\_\_  
Date of Examination