THE GOAL OF THE FARMINGDALE SCHOOL PUBLIC SCHOOLS IS TO ESTABLISH OURSELVES AS A HIGH ACHIEVING SCHOOL DISTRICT AS EVIDENCED BY HIGH LEVELS OF STUDENT PERFORMANCE IN ALL AREAS.

EMPLOYEE REQUEST FOR ACCOMMODATION - MEDICAL INFORMATION FORM

Date: _____

Employee's Name: _____Address:_____

Tel#_____ Job Location: _____ Position: _____

MEDICAL CONDITION: _____

Accommodation Requested/Duration_____

Indicate below, how your medical condition specifically hinders or prevents you from carrying out your job responsibilities:

_____

_____

_____

AFTER filling out above, please give to your PHYSICIAN to complete this form:

MEDICAL DIAGNOSIS: _____

Restrictions/limitations: _____

Please Attach:

1. Copies of all medical records and progress notes for the past 12 months.
2. Copies of laboratory tests, X-ray, CT, MRI, PFT's, or any other testing done to support the need for the accommodation.
3. Consultative reports, (e.g., referred to allergist, pulmonologist, etc.)
4. Accommodations at home.

Specify below all current medications:

1._____Dose:_____ Frequency:_____

2._____Dose:_____ Frequency:_____

3._____Dose:_____ Frequency:_____

Physician's Signature: _____ Date: _____

Physician's Stamp:

Please return this form to the building principal.

H-86C
Employee Request for Accommodation
Rev. 6/20/16

APPROVED_____ DISAPPROVED_____

Signature _____

THE GOAL OF THE FARMINGDALE SCHOOL PUBLIC SCHOOLS IS TO ESTABLISH OURSELVES AS A HIGH ACHIEVING SCHOOL DISTRICT AS EVIDENCED BY HIGH LEVELS OF STUDENT PERFORMANCE IN ALL AREAS.

HEALTH OFFICE

STUDENT REQUEST FOR ACCOMMODATION - MEDICAL INFORMATION FORM

Date:_____

Student's Name:_____ **Date of Birth:** _____

School:_____ **Grade:**_____

MEDICAL CONDITION: _____

Accommodation Requested/Duration_____

Indicate below, how your child's medical condition specifically hinders or prevents him/her from participating in daily school activities:

_____

_____

_____

AFTER filling out above, please give to your PHYSICIAN to complete this form:

MEDICAL DIAGNOSIS: _____

Restrictions/limitations: _____

Please Attach:

1. Copies of all medical records and progress notes for the past 12 months.
2. Copies of laboratory tests, X-ray, CT, MRI, PFT's, or any other testing done to support the need for the accommodation.
3. Consultative reports, (e.g., referred to allergist, pulmonologist, etc.)
4. Accommodations at home.

Specify below all current medications:

1. _____Dose:_____Frequency:_____

2. _____Dose:_____Frequency:_____

3. _____Dose:_____Frequency:_____

Physician's Signature:_____ Date:_____

Physician's Stamp:

Please return this form to the school nurse.

APPROVED_____ DISAPPROVED_____

Signature_____