**MEDICAL STATEMENT OR HEALTH ASSESSMENT STATEMENT**

Child’s Name: Child’s Birthdate: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Return to: Date needed: Fax #

**This child has been referred to determine special education eligibility. Oregon law requires that a medical statement or health assessment be obtained for some disabilities. *This information is urgently needed* to determine appropriate services for the child and *to comply with federal timelines* for the special education evaluation. Please answer all questions in row(s) with checked boxes and sign below.**

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| --- | --- |
| **1.**  | **Does child have a vision problem? Yes No** |
| **If yes**, check each of the following that apply:Child’s residual acuity is 20/70 or less in the better eye with correction. Child’s visual field is restricted to 20 degrees or less in the better eye.Child has an eye pathology or progressive eye disease that is expected to reduce residual acuity or visual field to one of the criteria listed above.Assessment results are inconclusive and child demonstrates inadequate use of residual vision. |
| **Additional information about the vision problem(s).** |
| **2.**  | **Does child have a hearing problem? Yes No** |
| **If yes**, complete the following:Child has a sensory-neural hearing loss.Child has a conductive hearing loss that: is is not treatable.The use of amplification: is is not appropriate. |
| **Additional information about the hearing problem(s).** |
| **3.**  | **Does child have a voice disorder? Yes No** |
| **If yes, additional information about the voice disorder is needed.** |
| **4.**  | **Does child have relevant medical issues that contribute to speech/language problem? Yes No** |
| **If yes, a description of the medical issue(s) contributing to speech or language problem is needed.** |
| **5.**  | **Does child have an impairment that is expected to last more than 60 calendar days? (Mark all that apply):*** **Autism Spectrum Disorder**

**Yes No*** **Health Impairment Yes No**
* **Orthopedic Impairment Yes No**
* **Motor Impairment Yes No**
* **Traumatic Brain Injury caused by an external force Yes No**
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| **If yes, a diagnosis or a description of the impairment(s) identified above is required.** |
| **6.**  | **Has child been diagnosed with other physical, medical, sensory or mental health condition(s) that may affect his/her educational performance? Yes No** |
| **If yes, the diagnosis and a description of the diagnosis are required.** |

Medical/Health Professional’s Signature & Title: Date: Medical/Health Professional’s Printed Name & Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_