MEDICAL ACCOMMODATIONS REQUEST FORM

Office of School Health | School Year 2025-2026

Student's health care practitioner completes this form, and parent submits it to the 504 Coordinator or IEP team with attached: Request for Health Services/Section 504 Accommodations Parent Form with HIPAA Authorization (for new or modified requests), Medication Administration Form (MAF) and/or Medically Prescribed Treatment Form, and any additional supporting documentation from practitioner/provider.

Student Name: ________________________________ *OSIS #:* ______________ *Student's Date of Birth:* ______________

☐ 504 Request ☐IEP Request IEP Classification: ______________________

HEALTH CARE PRACTITIONERS COMPLETE BELOW

MEDICAL INTERVENTION

Medical Diagnosis ____________________ /ICD-10 Code/DSM-V Code(s): _____._____ _____._____ _____._____

If the request is for a diagnosis of allergies/anaphylaxis, diabetes, or seizure disorder, please complete the Medical Accommodations Request Form Addendum.

This condition is: ☐ Acute ☐ Chronic Expected duration of accommodation: ______ weeks

Request for: ☐ nursing services ☐ paraprofessional support ☐ transportation ☐ other (see Other Services)

Requests for nursing or paraprofessional support, will be reviewed on a case-by-case basis to determine whether the student needs 1:1 support or school-based support. When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse. Trained paraprofessionals may administer epinephrine and glucagon; all other medications, including insulin, must be administered by a nurse. Requests for transportation accommodations will be reviewed on a case-by-case basis. Prior to commencement of services, MAFs must be submitted for all medications, supervision, and monitoring, and Medically prescribed Treatment Forms submitted for clinical procedures performed by OSH and its agents during school hours or DOE programs or activities.

Student's current clinical status *(level of control, current management plan, pending evaluations, etc.)*:

Type of Medical Intervention:	Intervention Needed
☐ Administration of Medications Please complete and submit all applicable Medication Administration Forms (MAFs: Allergy & Anaphylaxis, Asthma, Diabetes, General, Seizure). ☐ Emergency Medications (e.g. glucagon, rectal diazepam) Please list all emergency medications, including time frame for administration Will student require daily administration of medication during school hours? ☐ Yes ☐ No Will student require in-school medications 3 or more times per day? List daily medications here, and attach MAFs. ☐ Yes ☐ No	☐ during school ☐ during transport
☐ Procedures and Treatments, Routine and Emergency *(e.g., suctioning, airway management, vagal nerve stimulator) Please complete and submit the Request for Provision of Medically Prescribed Treatment Form (Non-Medication)* *Please list, including timing and frequency of administration during the school day.*	☐ during school ☐ during transport
☐ Equipment Management *(e.g., ventilator, oxygen) Please complete the Request for Provision of Medically Prescribed Treatment Form (Non-Medication)* Please list all equipment that will accompany the student during school and/or transport:	☐ during school ☐ during transport
☐ Other Services *Please complete all appropriate forms (MAFs, Request for Provision of Medically Prescribed Treatment Form, if applicable)* ☐ air conditioning ☐ ambulation assistance ☐ elevator pass ☐ other Please list:	☐ during school ☐ during transport

PROVIDERS, PLEASE SIGN PAGE 2 →

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STUDENT CONSIDERATIONS

Supervision/Monitoring Required: ☐ none ☐ during school ☐ during transport

Supervision/Monitoring Frequency: ☐ continuous ☐ other

Please describe the additional supervision/monitoring needed, including the tasks/responsibilities:

Is the student considered to be medically unstable (At risk for medical decompensation during school or transport)?

☐ Yes (please describe below) ☐ No

Is the student considered to be behaviorally unstable (poses a danger to themself or to other students)?

☐ Yes (please describe below) ☐ No

Does the student currently utilize the following: ☐ Crutches ☐ Cast ☐ Wheelchair ☐ Walker ☐ Other: ___________

Please list any other clinical concerns relevant to supporting the student during the school day and/or during transport (Attach additional information if needed)

How does this diagnosis affect educational performance? Does the diagnosis have an impact on learning, participation, or attendance in school? If so, please describe.

CONTACT INFORMATION & ATTESTATION

Phone number - Office: ______________________Cell: ____________________Email: ____________________________

Best days to be reached:

☐ Mon-Time: _________ ☐ Tue-Time: _________ ☐ Wed-Time: _________ ☐ Thu-Time: _________ ☐ Fri -Time: _________

I attest that I have provided clinical services to this student and that the information above is complete and clinically accurate as of the date provided below.

Provider's Name (print): ____ License #: ____________________________

Provider's Signature: ____ Date of completion: _____________________

MEDICAL ACCOMMODATIONS REQUEST FORM ADDENDUM 2025-2026

To Completed by the Student's Health Care Practitioner

Student Name: DOB: Student ID#:

Allergies/Anaphylaxis

(Note Available School-Specific Allergy Resources listed below)

List allergen(s):

Source of allergy documentation: Skin Testing Blood Test Parental Report

History of Anaphylaxis? Yes No

If yes, specify system(s) affected: Respiratory Skin GI Cardiovascular Neurologic Medications

Medications:

Was an **Allergy/Anaphylaxis** MAF completed? Yes No

Does the student have a history of developmental or cognitive delay? Yes No

If yes, specify diagnosis/diagnoses: ____________________

Does the student have prior experience with self-monitoring? Yes No

Can the student:

- Independently self-monitor and self-manage?
- Recognize symptoms of an allergic reaction?
- Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?
- Follow safety measures established by a parent/guardian and/or school team?
- Understand not to trade or share foods with anyone?
- Understand not to eat any food item that has not come from or been approved by a parent/guardian?
- Wash hands before and after eating?
- Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?
- Carry an epinephrine auto-injector?

Provider Signature: ____________________

Diabetes

When was the student diagnosed with diabetes? ____________________

Was a **Diabetes MAF** completed for this student? Yes No

Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? ☐ Yes ☐ No

If yes, please specify: ____________________

Can the student identify symptoms of hypoglycemia? Yes No

Can the student notify an adult when they feel that their blood glucose is not normal? Yes No

What is the plan to transition the student to independent functioning? ____________________

Provider Signature: ____________________

Seizure Disorder

Type of Seizure: ____________________

Frequency of Seizures ____________________

Medication(s), including emergency medications: ____________________

Was a **Seizure MAF** Completed? Yes No

Are the seizures well-controlled by the current medication regimen? Yes No

Does the student require routine or prn emergency medication in school? Yes No

If yes, has an MAF been completed? Yes No

Other associated signs and symptoms, including medication side effects: ____________________

Number of seizure-related ER visits during the past year: ____________________

Number of seizure-related hospitalizations/ICU admissions: ____________________

Frequency of office visits/monitoring: ____________________ Weeks Months

Last Office Visit: ____________________

Activity Restrictions: ____________________

Provider Signature: ____________________

DO NOT WRITE BELOW - SCHOOL USE ONLY

School-Specific Allergy Resources:

- ☐ Allergy Table(s) in the lunchroom: ______ staff members for supervision
- ☐ Allergy Table(s) in the classroom: ______ staff members for supervision
- ☐ General Staff Training for Epinephrine administration: ______ staff members trained
- ☐ Student-Specific Training for Epinephrine administration: ______ staff members trained
- ☐ Allergy Response Plan received from school nurse
- ☐ Other: ____________________

School-Specific Diabetes Resources:

- ☐ General Diabetes Basics Staff Training
- ☐ Student-Specific Staff Training for Glucagon administration
- ☐ Diabetes Care Plan from school nurse
- ☐ Other: ____________________

Name of Principal or Principal's Designee: ____________________