



*Education that inspires... Opportunities for all*  
**GURNEE SCHOOL DISTRICT 56**

3706 Florida Avenue • Gurnee, IL 60031 • 847-336-0800 • www.d56.org

**Physician Information  
Diagnosis Request**

*District 56 is to send a signed release of information with this letter.  
This form is confidential in nature and will be used to validate a 504, Individualized Health Plan, or IEP student plan.  
This form should be used only for existing diagnoses.*

Date: \_\_\_\_\_ Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

This form is to be completed by the attending physician.

This child has been diagnosed with:

- 1.) \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date: \_\_\_\_\_
- 2.) \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date: \_\_\_\_\_
- 3.) \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date: \_\_\_\_\_

When was the last time you evaluated the child? Date: \_\_\_\_\_

Is the child undergoing treatment for this condition? YES  NO

Name of medication(s) and dosage: \_\_\_\_\_  
\_\_\_\_\_

Are you, the physician, treating all of the above diagnoses? YES  NO

If no, which diagnoses: \_\_\_\_\_

Is the family following the prescribed treatment (medical management plan)? YES  NO

Do you think the impairment may impact the child's ability to access an education equal to his/her non-disabled peers?

YES  NO  Unsure

Comments:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature \_\_\_\_\_ Date

\_\_\_\_\_  
Physician's Name (Please Print) \_\_\_\_\_ Physician's Phone Number

