|  |  |  |  |
| --- | --- | --- | --- |
| Staff: |       | Position: |       |
| Student: |       | DOB: |       |
|  |  |

Dear Dr      :

We are evaluating the above student for eligibility as a student with a disability as defined by the Michigan Administrative Rules for Special Education. The disability we are considering is Other Health Impairment, which is defined by the special education regulations as:

 "(9) Other health impairment means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that - (i) is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and (ii) adversely affects a child's educational performance."

A medical diagnosis is a required component of multiple criteria that must be met to determine eligibility. In addition to the medical diagnosis, the multidisciplinary evaluation team will assess if the health problem has a significant impact on the student’s educational performance.

Your prompt attention to this request is appreciated to enable the evaluation to be completed within state timelines. If you have questions, please contact me using the contact information listed below.

Thank you so much for your help in this process.

|  |  |
| --- | --- |
| Medical Diagnosis (List): |       |
|  |       |
| **Check below if any of the following areas are affected by the medical condition and describe the nature and degree of impact in each area checked**. |
| [ ]  | Strength |       |
| [ ]  | Vitality |       |
| [ ]  | Alertness |       |
| Restrictions, if any: |       |
| Physical adaptations, if any: |       |
| Medications, if any: |       |
| Is this a life-long condition: | [ ]  | Yes | [ ]  | No | [ ]  | Uncertain |
| Physician Name: |       |
|  | (Print) |
| Physician Signature: |       | Date: |       |
| Please return by fax to: Attn: |       | Telephone: |       | Fax: |       |