Norwell Public Schools
Office of Student Services • Health Services
Catherine McInnis, R.N., Norwell High School • Kelly Roche, R.N., Norwell Middle School
Kristen Isola, R.N., Vinal Elementary School • Jacqueline Cregg, R.N., Cole Elementary School

Norwell Public Schools • 322 Main Street • Norwell, MA 02061 • v:781.659.8800 • f:781.659.8805 • norwellschools.org

Dear Parents/ Guardians,

As part of the process for a comprehensive evaluation, Norwell Public Schools is proposing the completion of a Medical Assessment. This assessment is essential to the team when they meet to determine the eligibility for Special Education and/or related services.

The Medical Assessment allows the team to “rule out” the presence of any medically relevant information which may explain any potential difficulty. Alternatively, the Medical Assessment may provide valuable information to the team when developing a comprehensive picture of the student progress and functioning.

Attached to this letter is the Medical Assessment which the district is proposing to be a part of this Initial (or Re-)Evaluation team meeting.Should you consent to this evaluation, please ask your child’s primary care physician or pediatrician to complete it and return it to the school at your earliest convenience.

If I can be of any further assistance, Please contact me directly by phone or email.

Sincerely,

Kelly Roche, R.N.-C, MSN, C.A.G.S.

Norwell Middle School Nurse
781-659-8814 prompt 3
Kelly.roche@norwellschool.org

Medical Assessment

Pursuant to 603 CMR 28.04

To: Office of Student Services-Health Services From: Child's Physician

Directions: This form should be completed and signed by a physician licensed to practice in the Commonwealth of Massachusetts. It may be used as a comprehensive report of relevant findings or as the cover sheet for an attached narrative medical report. It should be returned:

To: _____by_____
(School Nurse) (Date)

Student's Name:_____Tel.#:_____
_____
Address:_____
(Street City/Town State Zip Code)

Physician's Name:
_____
Address:_____
(Street City/Town State Zip Code)

DATE OF EXAMINATION:_____

Check One: ___ Primary Care ___ Consultant ___ School Physician ___ Other

If a consultant, please specify specialty:_____

Please answer the following questions and complete, where appropriate, a narrative explanation of your responses:

1. Are there aspects of this student's health-related history that have a bearing on his/her educational needs?
   __ Yes __ No __ Possibly Please describe. __ See Below __ See Narrative
   Narrative:

2. Are there findings on this student's standard physical examination that might affect educational planning?
   __ Yes __ No __ Possibly Please describe. __ See Below __ See Narrative
   Narrative:

3. Are there specific neurological, sensory or other handicapping conditions noted? Please describe, and If possible, note how these may affect educational planning?
   __ Yes __ No __ Possibly Please describe. __ See Below __ See Narrative
   Narrative:

4. Is the student receiving any medications and/or other therapies that might affect educational planning?
   __ Yes __ No __ Possibly Please describe. __ See Below __ See Narrative
   Narrative:

5. Are there any educationally relevant developmental findings resulting from your examination?
   __ Yes __ No __ Possibly Please describe. __ See Below __ See Narrative
   Narrative:

6. Do you have any general observations or knowledge of this student that might be helpful?
   __ Yes __ No __ Possibly Please describe. __ See Below __ See Narrative
   Narrative:

7. Do you have any recommendations or suggestions for this student's educational plan? Please include any limitations or constraints on participation in various school activities.
   __ Yes __ No __ Possibly Please describe. __ See Below __ See Narrative
   Narrative:

8. Can this student participate in the regular physical education program?
   __ Yes __ No __ Possibly
   If not, what modifications would you recommend? __ See Below __ See Narrative
   _____

9. Do you feel it would be important for you to attend the evaluation TEAM meeting? Can you suggest any times that are most convenient for you?
   __ Yes __ No __ Possibly Days _____ Times _____
   It may not be possible to conduct the meeting at these times. If it is not possible for you attend
   Who will serve as your designee?
   Name: _____

10. Do you wish to have a copy of this student's educational plan for your records? ___ Yes ___ No

11. Please identify any **individually medically necessary** accommodations that the student should be provided in order to access the educational program (please be as specific as possible):

    _____

_____ _____
(Signature) (Date)