



4. Please describe the functional limitation and/or behavioral manifestations (e.g., easily distracted, poor concentration, difficulty formulating and executing plan of action, difficulty coping with unexpected obstacles, panics in unfamiliar surroundings and situations, etc.) and recommendation you have prescribed:

BEHAVIOR

RECOMMENDATION

_____	_____
_____	_____
_____	_____
_____	_____

5. Please list any medications prescribed and the expected side effects, especially on cognition and learning activities.

MEDICATION

SIDE EFFECTS

_____	_____
_____	_____
_____	_____

6. Please disclose information you have concerning this student's intellectual capabilities. Please include a copy of any psychological/educational reports for our review.

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Provider's Name: \_\_\_\_\_ Title \_\_\_\_\_ License # \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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