



DIAGNOSTIC STATEMENT

Child's Name: _____ **Date of Birth:** _____ **Class** _____

School: _____ **Phone Number:** _____

To the physician:

We need your professional diagnosis and recommendations for the school program in order to provide special services to better meet this child's specific needs.

According to my professional judgment _____ qualifies for special education services and meets the criteria of the following handicapping condition(s).

____ Visual Impairment (including blindness) ____ Hearing Impairment
____ Orthopedic Impairment (physical impairment) ____ Emotional Disturbance
____ Traumatic Brain Injury ____ Autism
____ Mental Retardation
____ Speech Language Impairment Specify _____
____ Specific Learning Disability Specify _____

____ No existing handicapping condition

____ Health Impairment Specify _____

Strengths: _____

Needs: _____

Specific Recommendations: (equipment, restrictions, therapy): _____

Primary Handicapping Condition: _____

Secondary Handicapping Condition _____

Date of Diagnosis: _____

Diagnostician: _____ **Date Signed:** _____

Title/Agency: _____