MIAMI-DADE COUNTY PUBLIC SCHOOLS

Clear Form

M E M O R A N D U M

Date: _____

TO: District Medical Consultant/University of Miami
Department of Pediatrics
Mailman Center for Child Development
1601 N. W. 12 Avenue
Miami, Florida 33136
Attn: Patrice Fike #3029

FROM: _____, Staffing Specialist
Regional Center _____

SUBJECT: **REQUEST FOR REVIEW OF MEDICAL DOCUMENTATION**

Please review the attached medical documentation for the following student:

Student: _____ ID #: _____

Assigned School: _____

Exceptionality: _____

This request is for: _____

_____

_____

DOCUMENTS ATTACHED:

_____ IEP (Current)
_____ 504 Accommodation Plan
_____ Consent Form for Mutual Exchange of Information
_____ Medical Request from Student's Doctor

If you have any questions, please contact me at 305- _____.

xc: Assistant Superintendent, Regional Center _____
Assistant Superintendent, Office of Special Education and Psychological Services
SPED Instructional Supervisor, Regional Center _____
Principal _____
District Medical Consultant Liaison (Mail Code 3334)

Medical Consultant Recommendation:

☐ Recommended ☐ Not Recommended
☐ Additional Information Needed _____
☐ Permanent Disability ☐ Needs Annual Review

_____ Date: _____
Signature of District Medical Consultant/University of Miami

Medical Case Review/Recommendation(s) attached.

FM-7250 (10-08)