PARENT TO PARENT of BROWARD COUNTY
d/b/a FND of BROWARD
ADVOCACY PROGRAM

Medical Evaluation Form

Name of Child: _____ DOB: _____

Parent/Guardian: _____

Address: _____

Phone: _____ e-mail: _____

PHYSICAN TO COMPLETE THIS INFORMATION

(This information will only be used for the purpose of establishing eligibility for advocacy services.)

PLEASE CHECK AT LEAST ONE OF THE APPLICABLE DIAGNOSES FOR THIS PATIENT

- ❑ AUTISM SPECTRUM DISORDER
- ❑ CEREBRAL PALSY
- ❑ INTELLECTUAL DISABILITY (IQ Below 70)
- ❑ EMOTIONAL / BEHAVIORAL DISABILITY
- ❑ HEARING or VISUALLY IMPAIRED
- ❑ DEVELOPMENTAL DELAY
- ❑ HIGH-RISK (Cognitive, language, or physical delay)
- ❑ EPILEPSY
- ❑ NEUROLOGICAL IMPAIRMENT
- ❑ PHYSICAL OR GENETIC ANOMALY with delay
- ❑ TRAUMATIC BRAIN INJURY
- ❑ SPEECH or LANGUAGE IMPAIRMENT
- ❑ SPECIFIC LEARNING DISABILITY
- ❑ OTHER HEALTH IMPAIRMENT _____

Physician's Signature: _____ SIGN HERE Date: _____

Print Physician's Name: _____

Phone Number: _____

Address: _____

Please return this form with **original signature** to:
Parent to Parent d/b/a Family Network on Disabilities, P.O. Box 260909, Pembroke Pines, FL 33026