Florida School Readiness

Early Learning Coalition
Indian River • Martin • Okeechobee

OFFICE OF Early Learning
LEARN EARLY. LEARN FOR LIFE.

Verification of Disability

TO BE COMPLETED BY CLIENT

I give consent for release of medical information to the Early Learning Coalition of Indian River, Martin and Okeechobee Counties, Inc. which will be used to determine my eligibility for School Readiness services.

Client Name: _____ Date of Birth: _____

Email Address: _____ Telephone: _____

Signature: _____ Date: _____

TO BE COMPLETED BY A PHYSICIAN LICENSED *under Chapter 458 or 459, F.S.*

The individual named above is currently receiving or has applied for School Readiness services. In order to determine if your patient is eligible for subsidized child care services and exempt from work requirements due to age or disability, please assist us by completing this form.

Please answer all the questions below:

Is there a medical disability? ☐ Yes ☐ No Date of disability diagnosis: _____

Is this disability due to age? ☐ Yes ☐ No

Does this disability prevent the individual from working? ☐ Yes ☐ No

Is the disability: ☐ Permanent ☐ Temporary, effective end date _____

"Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his/her official duty shall be guilty of a felony of the third degree punishable in F.S. 414.39"

_____ _____ _____

Print or Type Name of Licensed Physician | Signature of Physician | Date

_____

Mailing Address (Including City and Zip Code)

_____

Telephone Number:

Physician Stamp