ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

COMPLETE A RELEASE FOR EVERY 2 PROVIDERS

Chicago Public Schools

Consent for Release/Exchange of Student Records and Information

Student's Name: ____ Date of Birth: ____/_____/_______

I hereby give permission to release/exchange/disclose the following:

[X] **All School Student Records**, including, but not limited to: personally identifying information; cumulative-permanent record; special education records; academic transcript; discipline records; health records; attendance records; and test scores.

Only Specific School Records:

- [ ] Personally Identifying Information
- [ ] Special Education Record (e.g. IEP, Evaluations, 504 Plans)
- [ ] Cumulative/Permanent Record
- [ ] Health Records
- [ ] Disciplinary Records
- [ ] Progress Monitoring Data
- [ ] Attendance Records
- [ ] Test Scores
- [ ] Other (Specify): ____

Health/Medical Information:

- [ ] Any and all records in the possession of ___________________________________ including mental health, HIV and/or substance abuse records
- [ ] Records regarding treatment for the following condition or injury __________________________________
- [ ] Records covering the period of time between __________________ and __________________
- [X] Other: ALL MEDICAL/BEHAVIORAL HEALTH RECORDS THAT MAY IMPACT ON STUDENTS EDUCATIONAL PERFORMANCE.

This information is to be released/exchanged between:

Agency/Doctor: 1)__________________________2)__________________________

Phone: 1)______________________________2)______________________________

FAX 1)______________________________2)______________________________

AND

Chicago Public Schools, District #299
School/Department:_______________
Attn:____________________________

Purpose: This information is to be disclosed upon request and will be used for the following purpose(s):

- [X] Educational evaluation and program planning
- [X] Medical evaluation and treatment
- [X] Health assessment and planning
- [ ] Referral to a separate day school/residential facility+
- [X] Independent Educational Evaluation
- [ ] Other: ____________________________________

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 et seq.), and the *Illinois Mental Health and Developmental Disability Confidentiality Act* (740 ILCS 110/1 et seq.). I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent to the local school district representative. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district may not be protected by HIPAA Privacy Rules, but will become educational records protected by the *Family Educational Rights and Privacy Act* (20 U.S.C. Section 1232g). I understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I understand that I have the right to inspect and copy educational records and to challenge their contents. +I acknowledge that limiting the release/exchange or disclosure of records to one separate day school/residential facility may impact the District's ability to timely place the Student in a non-public facility.

This authorization is valid for one (1) calendar year from the date of signed consent indicated below.

____
Parent Signature Date

____
Student Signature* Date

____
Witness Signature Date

*Student signature required for mental health records if Student is 12 years of age or older

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

PARENT COMPLETES

CHICAGO PUBLIC SCHOOLS | CPS

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

______________________	______________	______________________
Name of Student	Birth Date	ID Number
______________________	______________	______________________
Address	Telephone	Zip Code

I ______________________ (mother, father, legal guardian) of the above named student, give permission to the school nurse to administer medication as requested by my child's health care provider

__________________________during school hours.
(name of physician)

I will bring the medication to school nurse or principal/designee in the original container appropriately labeled by the pharmacist or licensed provider.

____

Signature of Parent / Guardian

____

Address

____

City Zip

____

Home Phone Mobile Phone Business Phone

____

Date

EMAIL______________________________

*This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

PARENT COMPLETES

CHICAGO PUBLIC SCHOOLS | CPS

PARENT REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

STUDENT MAY NOT SELF-ADMINISTER ANY MEDICATION IN SCHOOL WITH OUT THIS FORM COMPLETED

_________________________________ _________________________________ _________________________

Name of Student Birth Date ID Number

_________________________________ _________________________________ _________________________

Address Telephone Zip Code

_________________________________ has requested that my child self-administer medication

Name of Physician

Self-administration of medication during school hours. I (Mother, Father, and Legal Guardian) give permission for _________________________ to take medication during school hours. My physician will also submit a written statement that my child is capable of self-administering the medication at school.

By signing this statement, I am also acknowledging that Chicago Board of Education its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by the pupil. I agree to also indemnify and hold harmless the Board and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication or use of an epinephrine auto-injector by the pupil.

____

Signature of Parent / Guardian

____

Address

____

City Zip

____

Home Phone Cell Phone Business Phone

____

Date

EMAIL____

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS CPS

PHYSICIAN COMPLETES

FOR ORAL HYPOGLYCEMICS OR INSULIN

PHYSICIAN'S REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

______________________________ ____________________ ________________
Name of Student Birth Date ID Number

______________________________ ____________________ ________________
Address Telephone Number Zip Code

The above named student has ____
Name of Disease, condition, or Syndrome

I am requesting that the above named student be allowed to self-administer the following medication **under adult supervision** during school hours:

________________________________ ________________________________
Name of Medication Type of Medication, i.e. Tablet, Liquid, Inhaler

________________________________ ________________________________
Dosage Time to be given

____
Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name________________________________ **Hospital Affiliation**______________
(Please print or type)

Address _________________________________**Telephone #** ____________**Fax #**____________

Physician's Signature ____ **Date** _______________

EMAIL____

*This request is valid for 1 year from date of signature. Any medication change or dose requires a new request form.

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN COMPLETES

FOR ORAL HYPOGLYCEMICS OR INSULIN

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

______________________ ______________________ ______________________
Name of Student Birth Date ID Number

______________________ ______________________ ______________________
Address Telephone Number Zip Code

The above named student has ____
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

______________________ ______________________
Name of Medication Type of Medication, i.e. Tablet, Liquid, Inhaler

______________________ ______________________
Dosage Time to be given

____Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name______________________**Hospital Affiliation** ____________
(Please print or type)

Address ______________________**Telephone #** __________**Fax #**__________

Physician's Signature ______________________**Date** ____________

EMAIL______________________________

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

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CHICAGO PUBLIC SCHOOLS | CPS

PHYSICIAN COMPLETES

FOR GLUCAGON

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

______________________	______________________	______________________
Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has ____

Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

GLUCAGON ______________ ***INJECTION*** ______________

Name of Medication | Type of Medication, i.e. Tablet, Liquid, Inhaler

______________________ ______________________

Dosage | Time to be given

____Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name______________________________**Hospital Affiliation** ______________

(Please print or type)

Address ______________________________**Telephone #** __________**Fax #**__________

Physician's Signature ______________________________**Date** ______________

EMAIL____

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

PHYSICIAN COMPLETES **PHYSICIAN'S REPORT ON CHILD WITH DIABETES**

____
(LAST NAME) (FIRST) (MIDDLE) (BD) (ID #)

____
(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

____
(PARENT'S/ GUARDIAN'S NAME) TELEPHONE SCHOOL

Dear Doctor,
The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a copy for your files.

____
School Nurse

Student diagnosed with ☐ **Type 1 Diabetes** ☐ **Type 2 Diabetes** **Diagnosed Date:** ____________________

Recommended Time(s) during the school day to check blood glucose (*check all that apply*)
☐ Before or After Breakfast ☐ Before or After Exercise ☐ Before or After Lunch ☐ When student exhibits symptoms of hyper/hypoglycemia

Student is ☐ independent ☐ needs monitoring ☐ entirely dependent ***performing blood glucose checks.***
Student is ☐ independent ☐ needs monitoring ☐ entirely dependent ***carbohydrate counting.***
Student is ☐ independent ☐ needs monitoring ☐ entirely dependent with administering ***insulin injections.***

Target Blood Glucose __________ mg/dl

Insulin /Oral Medication Dosage:____

☐ Administered before Breakfast ☐ Administered after **Breakfast**

☐ Administered before **Lunch** ☐ Administered after **Lunch**

Sliding Scale: Breakfast _____ Lunch _________

Snacks: Carbohydrate calculations needed ☐ Yes ☐ No

***Indicate Insulin/carb ratio**__________

_____ Units if blood glucose is _____ to _____ mg/dl
_____ Units if blood glucose is _____ to _____ mg/dl
_____ Units if blood glucose is _____ to _____ mg/dl
_____ Units if blood glucose is _____to _____ mg/dl
_____ Units if blood glucose is _____to _____ mg/dl
_____Units if blood glucose is _____ to _____ mg/dl
_____ Units if blood glucose is _____ to _____ mg/dl

For Students with Insulin Pumps Only:

Insulin Pump used to manage Diabetes ☐ **Yes** ☐ **No** **Type of Pump** _________________________

Student independent in Insulin pump management ☐ **Yes** ☐ **No. Needs Monitoring** ☐ **Yes** ☐ **No.**

Basal Rates: ____ (rate) **12am to** ____ (time), ____ (rate) ____ (time) **to** ____ (time), ____ (rate) ____ (time) **to** ____ (time), ____ (rate) ____ (time) **to** ____ (time)

Insulin / Carbohydrate ratio: ____________________ **Correction factor:** _______________________

*Restrictions on activity (if any)*____

Field Trip Recommendations: ____

Physician's Name_______________________________________**Hospital Affiliation** _____________________
(Please print or type)

Address ____**Telephone #** ______________**Fax#**________________

Physician's Signature ____**Date** __________________________