PHYSICIAN TO COMPLETE

H. Serv. 121 (Revised 11/04)

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REPORT ON CHILD WITH A CARDIAC CONDITION

____
(Last Name) (First) (Middle) (BD) (ID No.)

____
Home Address Zip Code Other Town

____
Father's Name Mother's Name Telephone

____
School Grade Non-Attending

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 duplicate copy for your files. ______________________________
School Nurse

DIAGNOSIS (Please Specify)____

BREIF HISTORY (date of onset, surgeries, important signs and symptoms)______________________________

____

FUNCTIONAL CLASSIFICATION (please check)

____ **CLASS I** Patients with cardiac disease, but without resulting limitation of physical activity. Ordinary physical activity does not cause fatigue, palpitation, dyspnea, or pain.

____ **CLASS II** Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or pain.

____ **CLASS III** Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or pain.

____ **CLASS IV** Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort or symptoms of cardiac insufficiency, even at rest. If any physical activity is undertaken discomfort is increased.

RECOMMENDATIONS

Prophylaxis treatment required ☐ Yes ☐ No Type ______________________________

Physical restrictions ☐ No ☐ Yes ___ Gym ___Stairs ___Recess ___Diet
(Please explain)____

Additional information and recommendations______________________________

____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		

LATEST PHYSICAL FINDINGS

Weight_____ Height_____ Blood Pressure_____ Pulse_____ Clubbing of fingers_____ Cyanosis_____

Thrills (intensity, location)______________ Murmurs (intensity, location,character)______________

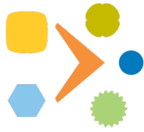
Electrocardiogram Date________ Results______________________________

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

Address ______________________________ **Telephone #** ______________ **Fax #**______________

*PHYSICIAN TO COMPLETE REGARDING*_________________________

[LIST MEDICAL CONDITION(S)]



ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

PHC 60 (Revised 11/04)

PHYSICIAN'S REPORT on STUDENT with MAJOR HEALTH PROBLEM

Name______________________________________ Age ____ Birth date ______ID#_____________________
Last First Middle

Home Address ____ Zip ____________

Parents/Guardians _____________________________________ School _______________________________

Dear Doctor:

For educational purposes, the Chicago Public Schools considers a major health problem to be any health condition that interferes with the student's ability to participate fully and independently in the educational program. Please provide information regarding this student. The information will be used to assess the student's health/nursing needs in the school setting, determine the least restrictive setting and identify related supportive services. Please return this to the school nurse promptly.

School Nurse ____Date____________________

MEDICAL DIAGNOSIS ____

____

____

____

HISTORY AND DETAILED DESCRIPTION OF HEALTH PROBLEMS (including results of special tests, x-rays, surgery, etc.)

____

____

____

____

TYPE OF MEDICAL TREATMENT STUDENT IS CURRENTLY RECEIVING (including medication)

____

____

____

____

PHYSICIAN'S REPORT on STUDENT with MAJOR HEALTH PROBLEM (page 2 of 2)

DO YOU ANTICIPATE THAT THIS STUDENT WILL NEED HOME TEACHING AT ANY TIME DURING THE SCHOOL YEAR? _______ No _______ Yes

If yes, please specify the condition(s) in which home teaching may be necessary (***NOTE:*** an additional application "***Medical Referral for Adjustment of Education Program***" is required)

____

____

____

ADDITIONAL CONCERNS ____

____

PHYSICAL ACTIVITY

	NONE or	SPECIFY LIMITATION
Distance Walking . . . . . . …………………………………………..	____	______________________________
Stairs . . . . ……………………………………	____	______________________________
Swimming ……………………………………………………	____	______________________________
Gym/Physical Activity ………………………………………..	____	______________________________

Special diet? Please describe ____

Does the student require adaptive equipment?

Braces _____ Glasses_____Helmet _____ Splints _____ Wheelchair _____ Other ____________________

Special Care Instructions:

____

____

How often should this student have a medical check-up? ____

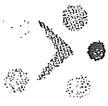
_______________________________________Next scheduled appointment_______________________
Date

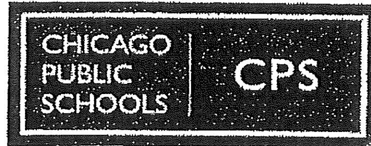
Physician's Name_______________________________**Hospital Affiliation** _______________________
(Please print or type)

Address _______________________________________**Telephone #** _____________ **Fax #**_____________

Physician's Signature ____ **Date** ___________________

PARENT TO COMPLETE


ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES



PARENT'S AUTHORIZATION TO RELEASE MEDICAL RECORDS

SCHOOL ______________________________ RE: ______________________________
Family Name First

HOME ADDRESS ______________________________ ID NUMBER ______________

DATE OF BIRTH ______________ *PARENT EMAIL(REQUIRED)* ______________

PARENTS CONTACT PHONE NUMBER (REQUIRED) ______________________________

I, ______________________________ Father / Mother / Guardian of ______________________________ Student

Hereby authorize **1.** ______________ **2.** ______________ **3.** ______________
DOCTOR(S) NAME

1. ______________ **2.** ______________ **3.** ______________
Dr. Phone and fax number

To release my child's medical records to the Chicago Public Schools. This information is required for the following reason (specify purpose):

TO ALLOW THE SCHOOL TO OBTAIN MEDICAL INFORMATION PERTAINING TO THE STUDENT'S MEDICAL AND OR BEHAVIORAL HEALTH CONDITION TO ESTABLISH A PLAN TO MAINTAIN HEALTH AND SAFETY OF THE STUDENT DURING SCHOOL HOURS. ALL INFORMATION OBTAINED BY THE SCHOOL IS KEPT STRICTLY CONFIDENTIAL UNDER HIPPA GUIDELINES. (If there are limits to the information you wish shared please note below or cross off above and initial)

____

____

____

This authorization for disclosure is valid until ______________, 20___ and, I understand that I may withdraw this authorization at any time. This authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA") privacy provisions.

I understand that I have the right to inspect the information disclosed.

______________ DATE

______________ SIGNATURE OF CONSENTING PARTY

______________ SIGNATURE OF STUDENT IF 13 OR OLDER

______________ SIGNATURE OF WITNESS / RELATIONSHIP TO THOSE CONSENTING