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:

☒ **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 _____
- ☒ 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):

- ☒ Educational evaluation and program planning
- ☒ Medical evaluation and treatment
- ☒ Health assessment and planning
- ☐ Referral to a separate day school/residential facility+
- ☒ 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

_____

Witness Signature Date

_____

Student Signature* Date

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

H. Serv. 121, Rev 1/19

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REPORT ON CHILD WITH A CARDIAC CONDITION

(Last Name) (First) (Middle) (DOB) (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's Signature _____ **Date** _____

*PHYSICIAN TO COMPLETE REGARDING*___Cardiac condition_____

[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** _____