ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

PHYSICIAN'S REPORT ON STUDENT WITH A CONCUSSION

_____ _____ _____

Name of Student | Birth Date | ID Number

_____ _____ _____

Address | Zip Code | Telephone Number

Dear Health Care Provider,
The School Nurse of the 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/School/Telephone Number

Student diagnosed with: ☐ Sports related concussion ☐ Other _____

Date of Diagnosis: _____**Follow up visit schedule date(s)** _____

Attendance: ☐ No attendance ☐ Partial attendance as tolerated ☐ Full Day attendance
Rest Breaks: ☐ Breaks as needed ☐ No breaks required

Visual Stimuli (check all that apply)
☐ Reduce exposure to computers, smart boards, and videos ☐ Reduce brightness on screens ☐ Consider use of books on tape
☐ Allow the student to wear a hat or sunglasses in school ☐ Turn off fluorescent lights as needed
☐ Seat student closer to the center of classroom activities (blurry vision)
☐ Cover 1 eye with patch/tape 1 lens if glasses are worn (double vision) ☐ Other _____

Audible Stimuli (check all that apply)
☐ Allow the student to have lunch in quiet area with a classmate ☐ Consider use of earplugs
☐ Limit or avoid band, choir, and shop classes ☐ Avoid noisy gyms and organized sports practices/games
☐ Give student early dismissal from class and extra time to get from class to class to avoid crowded hallways during pass time

☐Other _____

Work Load (check all that apply)
☐ Decrease workload ☐ Allow extra time to complete assignments ☐ Require only assignments necessary for mastery

☐ Other _____

Testing (check all that apply)
☐ Avoid testing or completion of major projects during recovery when possible
☐ Provide extra time to complete non-standardized tests ☐ Oral testing only
☐ Consider 1 test per day during exam periods ☐Consider the use of preprinted notes, note taker, scribe, or reader for oral test taking

☐ Other_____

Physical Exertion:
☐ No Physical Activity ☐ Modified/limited Physical Activity ☐ Begin Return to Play Protocol **Date** _____

May return to all physical activity without limitations: Date_____

Physician's Name_____ **Hospital Affiliation** _____
(Please print or type)

Address _____**Email Address**_____

Telephone # _____ **Fax #**_____

Physician's Signature _____**Date** _____

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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

Consentimiento para la Divulgación/Intercambio de Registros e Información del Estudiante

Nombre del estudiante _____ Fecha de Nacimiento: ____/_____/_____
mes día año

Doy permiso para que se divulgue/publique/intercambie lo siguiente:

☐ **Todos los registros escolares del estudiante**, incluyendo, pero no limitados a: información personalmente identificable; expediente cumulativo-permanente; registros de educación especial; registro académico; registro de disciplina; registro de salud; registro de asistencia; y puntajes de exámenes.

Sólo Registros Escolares Específicos:

☐ Información personalmente identificable
☐ Registro Cumulativo-Permanente
☐ Datos de Monitoreo de Progreso
☐ Registro de Educación Especial (Evaluaciones del IEP, Planes 504)
☐ Registro de Salud
☐ Registro de Asistencia
☐ Registro de Disciplina
☐ Puntajes de Exámenes
☐ Otro (Especificar): _____

Información de Salud/Médica:

☐ Cualquier y todos los registros en posesión de _____ incluyendo de salud mental, VIH y/o registros de abuso de sustancias
☐ Registros acerca del tratamiento para la siguiente condición o lesión: _____
☐ Registros que abarcan el período de tiempo entre _____ y _____
☐ Otro: ALL MEDICAL/BEHAVIORAL HEALTH RECORDS THAT MAY IMPACT ON STUDENTS EDUCATIONAL PERFORMANCE.

Esta información será divulgada/intercambiada entre: Agencia(s)/ Escuela(s):
1)_____ 2)_____
PHONE 1): _____ 2)_____
FAX: 1)_____ 2)_____

Y

Escuelas Públicas de Chicago, Distrito 299
Escuela/
Departamento:_____
Attn:_____

Propósito: Esta información es para ser divulgada por pedido y será utilizada para el/los siguiente(s) propósito(s):

☐ Evaluación educativa y planeamiento de programa
☐ Evaluación de salud y planeamiento
☐ Evaluación Educativa Independiente
☐ Evaluación médica y tratamiento
☐ Remisión a una escuela privada de educación especial/institución residencial+
☐ Otro: _____

Estas divulgaciones están autorizadas conforme con *Ley de Privacidad y Derechos Educativos de la Familia* (20 U.S.C. Sección 1232g), *Ley de Registros Estudiantiles Escolares de Illinois*, (105 ILCS 10/1 et seq.), la *Ley de Confidencialidad de Discapacidades del Desarrollo y Salud Mental de Illinois* (740 ILCS 110/1 et seq.). Comprendo que tengo el derecho de inspeccionar y copiar la información a ser divulgada, cuestionar sus contenidos, y limitar mi consentimiento a registros designados o a porciones de la información contenida en estos registros. Comprendo que puedo rescindir esta autorización en cualquier momento presentando una nota escrita al Representante de Distrito Local de que retiro mi consentimiento. Comprendo que mi retiro de esta autorización no será efectivo para acciones tomadas por el Distrito Escolar o por el Proveedor de Servicios de Salud desde mi autorización y antes de mi aviso de rescisión. Entiendo que la falta de autorización a la divulgación de registros puede tener un impacto negativo en la programación educativa y/o el tratamiento médico de mi niño(a). Reconozco que los registros de salud, una vez que sean recibidos por el Distrito Escolar, pueden no estar protegidos por la Reglas de Privacidad de HIPPA, pero se convertirán en expedientes educativos protegidos por la *Ley de Privacidad y Derechos Educativos de la Familia* (20 U.S.C. Sección 1232g). Entiendo que si me niego a firmar, esta negación no interferirá con la capacidad de mi niño de obtener cuidado de salud. Comprendo que tengo el derecho de inspeccionar y copiar registros educativos y cuestionar sus contenidos +Reconozco que limitar la divulgación/intercambio de registros a una escuela privada de educación especial/institución residencial puede tener impacto en la habilidad del Distrito de asignar el estudiante a una institución no pública.

Esta autorización será válida por un (1) año calendario a partir de la fecha de consentimiento firmado que se indica abajo.

_____ _ _____
Firma del Padre Fecha Firma del Estudiante* Fecha

_____ _
Firma del Testigo Fecha

*Se requiere la firma del estudiante para su consentimiento si el estudiante tiene 12 años de edad o más