

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** _____

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:

- | | |
|-------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> Personally Identifying Information | <input type="checkbox"/> Special Education Record (e.g. IEP, Evaluations, 504 Plans) |
| <input type="checkbox"/> Cumulative/Permanent Record | <input type="checkbox"/> Health Records |
| <input type="checkbox"/> Progress Monitoring Data | <input type="checkbox"/> Attendance Records |
| <input type="checkbox"/> Other (Specify): _____ | <input type="checkbox"/> Disciplinary Records |
| | <input type="checkbox"/> Test Scores |

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) _____ AND Chicago Public Schools, District #299
 Phone: 1) _____ 2) _____ School/Department: _____
 FAX 1) _____ 2) _____ Attn: _____

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

- | | |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Educational evaluation and program planning | <input checked="" type="checkbox"/> Medical evaluation and treatment |
| <input checked="" type="checkbox"/> Health assessment and planning | <input type="checkbox"/> Referral to a separate day school/residential facility ⁺ |
| <input checked="" type="checkbox"/> Independent Educational Evaluation | <input type="checkbox"/> 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

