*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** _____

PHYSICIAN TO COMPLETE

DEPARTMENT OF SPECIALIZED SERVICES
STUDENT HEALTH SERVICES
CHICAGO PUBLIC SCHOOLS

PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Name of Student _____ Birth Date _____ ID Number _____

Address _____ Zip Code _____ Telephone # _____

The above name student has _____
Name of Disease or Syndrome

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

Name of Medication _____ Type of Medication (tablet, liquid, capsule or inhaler) _____

Dosage _____ Time to be given _____

Possible side effects _____

STUDENT IS CAPABLE OF CARRYING INHALER ON PERSON. (circle one) YES NO

I certify that _____ has been instructed in the use and self-
Name of Student

administration of _____.

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

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

Phone # _____

Signature of Physician _____ Print Name of Physician _____

Address _____ Date _____

CHICAGO PUBLIC SCHOOLS

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 _____

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

Rev. 11/04

PARENT COMPLETES *** STUDENT MAY NOT SELF-ADMINISTER MEDICATION WITH THIS COMPLETED********

CPS CHICAGO PUBLIC SCHOOLS

PARENT REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

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, 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 Business Phone

_____
Date

********EMAIL (REQUIRED):_____******

PARENT COMPLETES

CHICAGO PUBLIC SCHOOLS

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 physician _____ during school hours.

NAME OF PHYSICIAN

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

_____
Signature of Parent / Guardian

_____
Address

_____
City Zip

_____
Home Phone Business Phone

_____ ****EMAIL(REQUIRED):_____****
Date

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

Rev 11/04

PARENT TO COMPLETE

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

CHICAGO PUBLIC SCHOOLS | CPS

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