



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 named 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.

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 _____

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

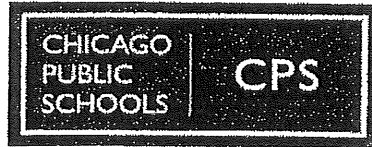
*This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.



PARENT TO COMPLETE

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**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 of _____
Guardian 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

