PHYSICIAN TO COMPLETE UPON VERIFICATION OF PREGNANCY. REQUIRED TO CLEAR STUDENT TO SAFELY ATTEND SCHOOL.
STUDENT IS ELIGIBLE FOR 6 WEEKS HOMEBOUND SERVICES STARTING THE DAY OF DELIVERY. COMPLETE HOMEBOUND FORMS AND RETURN TO SCHOOL NURSE AS SOON AS DUE DATE IS DETERMINED.

CPS

C H I C A G O P U B L I C S C H O O L S

Rev 11/04

HEALTH MONITORING/EMERGENCY RECORD FOR PREGNANT STUDENTS

(Last Name) (First) (Middle) (BD) (ID Number)

Home Address Zip Code Other Town

Father's Name Mother's Name Telephone

School Grade Non-Attending

In case of emergency contact:
NAME _____ PHONE _____

Address _____ Relationship to student _____

PHYSICIAN'S REPORT

LMP _____ EDC _____ Gravida _____ Para _____ Gestation _____mos/wks

First appointment _____ Frequency of appointments _____

Is student able to continue in a regular school program? _____

List restrictions (if any) _____

Can this student participate in physical education, swimming or driver's education (behind the wheel)?
Explain _____

List student's chronic health problems (asthma, sickle cell anemia, seizures, diabetes, etc.)

_____

Is this student taking medication other than routine vitamin and iron supplements? If yes, please list

_____

Date student is expected to begin maternity leave _____

Expected place of delivery _____

Additional comments/concerns _____

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

Address _____ **Telephone #** _____ **Fax#** _____

Physician's Signature _____ **Date** _____

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

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

Form 1 Medical Referral for Adjustment of Educational Program rev 7-2015

Section 1 is to be completed by the **parent**, **nurse or homebound coordinator** at the attendance school. **Sections 2,3,4,5** are to be completed by the **Physician. Section 6** is to be completed by the **School Nurse**. **ALL SECTIONS MUST BE COMPLETED BEFORE THE FORM WILL BE REVIEWED AND CONSIDERED.**

Some students need adjustments to their educational school program due to medical, physical or psychiatric conditions. In these unique instances, educational instruction may be provided in the home, hospital or treatment center. These instructional sites do not replicate actual classrooms and instruction is not a comparable alternative to daily school classroom instruction. Please complete this form for your patient who meets these distinctive conditions.

AN UPDATED MEDICAL REFERRAL WILL BE REQUIRED EVERY ONE TO THREE MONTHS DEPENDING ON THE NATURE AND EXTENT OF THE CHILD'S PRESENTING CONDITION. AN UPDATED REFERRAL MAY BE REQUIRED EVERY THREE (3) DAYS FOR INTERMITTENT STUDENTS with chronic conditions resulting in discontinuous attendance at school.

Send the **Medical Referral, Teacher Application,** and **Teacher Acknowledgment** to the Home and Hospital Instruction Program via email at homeandhospital@cps.edu.

1. STUDENT INFORMATION (completed by the School Nurse or School Homebound Coordinator)

Student's Name_____ **School Name**_____ **Area**_____

Today's Date_____ **Date of Birth**_____

Completed by_____ **CPS ID#**_____

Grade_____ **Parent or Guardian**_____

Home Phone Number_____**Cell Number**_____**Work Phone Number**_____

Home Address_____**Home Email Address**_____

2. PHYSICIAN INFORMATION (completed by the Physician)

Physician's Name (Print) _____**Physician's License Number**_____

Physician's Specialty (area of practice)_____

Phone_____**Fax**_____**Physician's E-Mail**_____

Hospital(s) Affiliation(s)_____

Physician's Signature_____**Date Signed**_____

3. STUDENT ELIGIBILITY (completed by the Physician)

Date of Most Recent Medical Examination _____

Diagnosis Affecting School Attendance_____

Pertinent Information Which Includes How the Student's Medical Condition Affects the Student's Ability to Attend School

_____

_____

Office of Diverse Learner Supports and Services | *Where Differences Matter*
Chicago Public Schools | 501 West 35th Street, Chicago, IL 60616
Phone: 773.553.1800

Specify Ongoing Treatment and/Interventions for Medical Condition that precludes the student's attendance in school

Medical Diagnosis_____ **Medications**_____

☐ **Pregnancy-Related Condition(s)**-Students who are pregnant are not eligible for homebound instruction unless there are complications associated with the pregnancy, such as toxemia or miscarriage.

Anticipated Delivery Date_____ **Actual Delivery Date**_____

Complications Associated with Pregnancy/Delivery? (Please Check One Box) ☐ **Yes** ☐ **No**

If yes, specify the complications _____

Health of the Baby_____

☐ **Postpartum/Aftercare-**Typically, students return to school after six (6) weeks of homebound instruction unless there were delivery complications, such as a Cesarean section.

4. TEACHING INSTRUCTIONAL DELIVERY SITE (COMPLETED BY THE PHYSICIAN). SELECT THE APPROPRIATE TEACHING SITE FOR THE STUDENT NAMED IN THIS REFERRAL.

☐ Hospital Teaching	☐ Treatment Center Teaching	□ Homebound Teaching	☐ Intermittent Home Teaching
Facility _____ **Name**_____ Student is hospitalized for an acute or chronic medical condition	**Facility** _____ **Name**_____ Student has been placed by the district or a court system	Student is anticipated to be to be absent	Student is chronically ill and may be absent periodically throughout the year
Start Date_____ **End Date**_____	**Start Date**_____ **End Date**_____	**Start Date**_____ **End Date**_____	**Start Date**_____ **End Date**_____

5. TRANSITION BACK TO SCHOOL (completed by the Physician)

☐ Return to school with **no restrictions**

☐ Restrictions are to be determined **after** return to school

☐ Return to school with designated restrictions (Specify the nature and extent of the restrictions)

Specify_____
_____

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6. SCHOOL NURSE INFORMATION (completed by School Nurse)

I_____ (print name of the school nurse) contacted the student's Physician on _____(specify the date). In addition, I reviewed all sections of the Medical Referral Form and consider the information to be complete and correct.

I_____(check one) ☐ **Agree** ☐ **Disagree with the need for homebound instruction.**

Print Name

Date Physician contacted_____

Date reviewed by School Nurse_____

School Nurse's signature_____

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