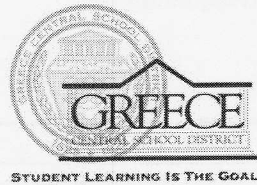
Please fill out and return to your school



STUDENT LEARNING IS THE GOAL

OFFICE OF STUDENT SERVICES
DISTRICT OFFICE
ADDRESS: 750 Maiden Lane, Rochester, NY 14615-1296
MAILING ADDRESS: P.O. Box 300, N. Greece, NY 14515-0300
TELEPHONE: 585.966.2900 **FAX:** 585.581.8205
WEB ADDRESS: www.greece.k12.ny.us

SCHOOL HEALTH SERVICES

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name ______________________________ Birthdate ______________

Healthcare provider ______________________________ Phone ______________

Address ______________________________ Fax ______________

Healthcare provider ______________________________ Phone ______________

Address ______________________________ Fax ______________

Healthcare provider ______________________________ Phone ______________

Address ______________________________ Fax ______________

I authorize my child's physician(s) and/or therapists listed above to exchange the following information with the school district staff listed below in order to provide a safe and appropriate environment/program for my child:

☐ School Nurse	☐ Immunizations/Physical exams to comply with NYS regulations
☐ Medical Officer	☐ Care or therapy plans for routine and emergent school management
☐ Physical Therapist	☐ Authorization for medications/treatment during school or on school trips
☐ Occupational Therapist	☐ Medical clearances as needed following an injury or change in condition
☐ Speech Therapist	☐ Medical orders required for therapy needs, evaluations, programming
☐ Athletic Trainer	☐ Physician referral for services (OT, PT, ST, other)
☐ Counseling Department	☐ Medical condition that may have an impact in the school setting, including transportation, home tutoring, classroom accommodations, attendance
☐ Special Education	
☐ Psychologist	☐ At patient's request with no specified purpose
☐ Other ______________	☐ Other ______________________________

Parent, please select one (Note: if you limit time frame, you may need to complete another form in the future):

_____This authorization is valid for as long as my child is enrolled in the district
_____This authorization is valid for the entire academic school year 20 - 20 ________
_____This authorization shall expire on ____/______/_____(MO/DD/YR)

I acknowledge that I have the right to refuse to sign this authorization and to revoke this authorization at any time by sending written request to my healthcare provider and to the District Administration at the above address. I understand that if I revoke this authorization, it may not be effective if the Protected Health Information was already disclosed before receipt of my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may no longer be protected by federal or state law. I understand that my child's enrollment is not dependent on my agreement to release or withhold information, except immunizations required by law. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and implementing regulations (34 C.R.F. § 99). A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the School District by the healthcare providers listed. If student is under 18 years of age, parent or legal guardian must sign consent form. If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act, then the parent/guardian must <u>also</u> sign consent form.

____
Signature of Parent, or Guardian Relationship Date

____
Signature of Student over 18 Date

GREECE CENTRAL SCHOOL DISTRICT

NYSED requires an annual physical exam for new entrants, students in Grades pre-K, K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

School: ______________________ **Gender:** ❑ M ❑ F **Grade:** ______________________

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal:
❑ Immunizations Given Today

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: ________
PPD: ❑ Positive ❑ Negative ❑ Not done Date: ________
Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: ________
Dental Referral ❑ Yes ❑ No ❑ Not done Date: ________

Significant Medical/Surgical History: ❑ See attached ______________________

____

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension
❑ Other: ______________________

Allergies: ❑ **LIFE THREATENING** ❑ Food: ________ ❑ Insect: ________ ❑ Other: ________
❑ Seasonal ❑ Medication: ______________________ ________

PHYSICAL EXAM

Height: ________ Weight: ________ Blood Pressure: ________ Date of Exam: ________

Body Mass Index: ___ ___ . ___	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❑ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❑ Negative ❑ Positive: ________

Specify any abnormality (use reverse of form if needed): ______________________

____

____

MEDICATIONS

Medications (list all): ❑ None ❑ Additional medications listed on reverse of form

Name: ______________________ Dosage/Time: ______________________

Name: ______________________ Dosage/Time: ______________________

If AM dose is missed at home: ______________________

I assess this student to be self-directed ❑ Yes ❑ No Student may self carry and self administer medication ❑ Yes ❑ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION / SCHOOL / PRESCHOOL

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work, school & preschool activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❑ **Specify medical accommodations needed for school:** ______________________ ❑ None

❑ **Known or suspected disability:** ______________________ ❑ Please monitor

❑ **Restrictions:** ______________________ ❑ Please monitor

❑ **Protective equipment required:** ❑ Athletic Cup ❑ Sport goggles/impact resistant eyewear ❑ Other: ________

(Stamp below)

Provider's Signature: ______________________ Phone: ________

Provider's Name/Address: ______________________ Fax: ________

Parent Signature: ______________________ Date: ________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.