McQUAID JESUIT

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
☐ Medical officer
☐ Physical Therapist
☐ Occupational Therapist
☐ Speech Therapist
☐ Athletic Trainer
☐ Counseling Department
☐ Special Education
☐ Psychologist
☐ Other _____

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

This authorization will be valid for the student's entire time spent at McQuaid.

I acknowledge that I have the right to refuse to sign and to revoke this authorization at any time by sending written request to my healthcare provider and to the McQuaid Nurses' Office. 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 will be provided to me upon request. I understand that this form 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

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

Health Certificate/Appraisal Form

Name: _____ Date of Birth:_____ Grade: _____

IMMUNIZATIONS/HEALTH HISTORY

DPT/DT						
Tdap				Varicella		
Polio (OPV/IPV)						
Hepatitis B						
Hib						
MMR				MCV4		

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 _____

Other Immunizations:
_____
_____

Significant Medical/Surgical History: ___ See attached _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

PHYSICAL EXAM

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

Body Mass Index: ____ ____•____

Weight Status Category (BMI Percentile):

☐ Less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision-without glasses/contact lenses	R	L	
Vision –with glasses/contact lenses	R	L	
Vision- Near Point	R	L	
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 (attaché additional form if needed): _____
_____

MEDICATIONS

Medications (list all): ☐ None

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

☐ Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
____ Limited contact: cheerleading, 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, jump rope

☐ 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: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

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

11/14