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.csd.org

Please fill out and return to your school

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 ____

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

STUDENT HEALTH SERVICES INFORMATION

Please fill out and return to the school nurse.

TO BE COMPLETED BY PARENT OR GUARDIAN
The following information concerning your child is requested in order to complete the Health Record of the school.

STUDENT'S LEGAL NAME ____________________ GRADE ________

PHYSICIAN'S NAME ____________________ PHYSICIAN'S PHONE NUMBER ________

Please fill in the year that your child has had any disease or condition listed below:

Diseases

Chicken Pox ____________
Elevated Lead Levels ____________
German Measles ____________
Measles ____________
Mumps ____________
Rheumatic Fever ____________
Scarlet Fever ____________
Strep Throat ____________
Tuberculosis (TB) ____________
TB in Associates ____________
Other ____________

Blood Disorder ____________
Convulsions or Neurological Disorder ____________
Chronic Illness ____________
Dental Problems ____________
Diabetes ____________
Ear Problems ____________
Eye Problems:
- Corrective Lenses Yes ☐ No ☐
- Are lenses impact-resistant? Yes ☐ No ☐
- When should glasses be worn?
  - Boardwork ☐ Paperwork ☐
  - Phys. Ed./Sports ☐ All the time ☐
- Loss of vision in one eye Yes ☐ No ☐
- Visually impaired Yes ☐ No ☐

Conditions

Accident, Injury, Hospitalization ____________
Attention Deficit Disorder ____________
Allergy to *(list)*:
- Food ____________
- Insect ____________
- Medicine ____________
- Life-threatening? Yes ☐ No ☐
- *If yes, are medications needed for school?* Yes ☐ No ☐

Asthma ____________
Arthritis ____________
Autistic Spectrum Disorder ____________
Behavioral Problem ____________

Hernia ____________ Repaired ________
Heart Defect ____________
High Blood Pressure ____________
Language/Speech Disorder ____________
Learning Disability ____________
Loss/Impairment of one of paired organs: (kidney, testicle) ____________
Mental Health Diagnosis ____________
Orthopedic Problems ____________
Scoliosis ____________
Current Prescribed Medications:
Daily ☐ As needed ☐
Reason ____________

LIFE-THREATENING CONDITION

My child has one of the following life-threatening conditions and will need an emergency care plan completed by the school nurse and myself with written guidance from our private physician. I understand that it is my responsibility to provide physician orders and any prescribed life saving medication to the school nurse. I understand that if my child needs to carry life saving medications, I must receive prior administrative approval and must provide a second dose in the school health office in the event my child misplaces the life saving medicine.

Please Specify:

Life-threatening allergy:
- ☐ Food ____________
- ☐ Insect ____________
- ☐ Medicine ____________

☐ Asthma
☐ Diabetes
☐ Elevated Lead Levels
☐ Poorly controlled seizures
☐ Severe swallowing problems or choking
☐ Significant heart disease
☐ Other ____________

SIGN HERE

PARENT/GUARDIAN SIGNATURE ____________ DAYTIME PHONE NUMBER ____________ DATE ________