ROME CATHOLIC SCHOOL

800 Cypress St Rome NY,13440

Authorization for Use or Disclosure of Protected Health Information

2022-2023 SCHOOL YEAR

STUDENT'S NAME: _____ DOB: _____ Grade: __

Health Care Provider Names	Address	Phone	FAX
_____	_____	_____/	_____
(Primary Pediatrician)			
_____	_____	_____/	_____
_____	_____	_____/	_____
_____	_____	_____/	_____

(If you request an individual release of information form for a specific HCP, contact the school nurse)

I give permission for the District to obtain medical records from my child's healthcare providers and for the District nurses to communicate with the health care provider and hcp staff. This FORM is **valid from 7/1/2022 through 6/30/2023.**

Medical information/records to include the following:

- Physicals (health appraisals),
- Immunizations,
- Referrals,
- Consultations,
- Lab tests and other test results, and
- Other _____.

(Draw a line through any records above that you request to be excluded)

I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that my health care provider has relied on the use or disclosure of the protected health information.

I understand that when this information is used by or disclosed to the District pursuant to this authorization, it may be shared with school personnel pursuant to FERPA.

*** _____ _____ _____

PRINT Parent/Guardian Name **Parent/Guardian Signature** **Date**

COMPLETE OTHER SIDE FOR MEDICAL INFORMATION

Student Name: _____ **DOB:** _____ **Grade:** _____**HR:** _____ **School Year: 2022-2023**

Medical Information

CHECK ALL THAT APPLY - EXPLAIN as NEEDED

- **SEVERE ALLERGY**
- Bee
- Latex
- Food: _____
- Drug: _____
- Other: _____

Describe REACTION

- Anaphylactic Reaction
- Rash
- Other: _____

Date of last reaction: _____

- ***EpiPen*** required at school
- ***Benadryl*** needed at school
- **Asthma**
- *Inhaler* used at school
- *Nebulizer* used at school
- **Blood Disorder**

Explain: _____

- **Cancer**

Explain: _____

- **Concussion** - Date: _____

Loss of Consciousness - Yes No

- **Diabetes**
- Taking Insulin
- Type 2 Diabetes
- **Heart Problem**

Explain: _____
Limitations: _____

- **Seizures** Date of Last: _____

Type: _____

- **Other Allergies**
- Animals
- Environmental
- Gluten/Wheat
- Lactose
- Other: _____
- **Acid Reflux / GERD**
- **Bowel Problems**

Explain: _____

- **Urinary Problems**

Explain: _____

- **Skin Problems**
- Eczema
- Psoriasis
- Other: _____

Explain: _____

- **Scoliosis**

Limitations: _____

- **Hearing Problems**
- Hearing Aid
- Speech Delay
- Other: _____

- **Vision Problems**
- Glasses/Contacts
- Color Blindness
- Other: _____

Explain: _____

- **ADHD** Date Diagnosed: ____
- **Asperger's**
- **Autism**
- **Cerebral Palsy**
- **Cystic Fibrosis**
- **Depression**
- **Developmental Delay**
- **Down's Syndrome**
- **Eating Disorder**
- **Oppositional Defiant Disorder**
- **Rheumatoid Arthritis**
- **Sickle Cell**

Other Medical Concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

- **NONE *(NO CONCERNS)***

Contact your child's SCHOOL NURSE with any CHANGES
CHECK HERE IF NONE

Medication Information

List "ALL" child's medications and "CHECK" medications to be given during the school day

• ***Check here*** - MAY apply sunscreen to your child, must send in your own bottle- NO AEROSOL	•	•
•	•	•
•	•	•

Medications given at school must have ORDERS signed by the parent/guardian AND HCP.
Medications must be delivered to school in "ORIGINAL" pharmacy OR "over the counter" containers.

Physical Examination (Health Appraisal)

The Education Law and Regulations of the Commissioner of Education require ***Physical Examinations*** to be completed for **new enrollees AND students in Pre-K OR K, Grades 1, 3, 5, 7, 9 and 11** (Dental certificates are also *requested*)

This examination should be done by the student's own Health Care Provider.

_____ I shall have this examination done by my own health care provider and return the report within 30 days.
(If report is not returned, your child will automatically be included with the school physicals)

_____ Schedule the examination to be done by the ***School Health Service***. (Students entering after date of school physicals need to provide exam done by own health care provider)

Parent/Guardian Signature: _____ Date: _____

COMPLETE & SIGN the BACK for PHYSICAL to be RELEASED to the School Nurse