SYRACUSE CITY SCHOOL DISTRICT

Anthony Q. Davis, Sr., Superintendent of Schools

Health Services **Nancy Bailey, Director of Health Services**

Dear Parent or Guardian,

Your child is scheduled to be examined on _____.

Please complete the form below and return it to your child's school health office by _____.

☐ I give permission for my child to receive his/her physical exam in school

☐ My child had a physical exam on _____ and I have enclosed a copy.

☐ My child has an appointment on _____ with health care provider,

_____. I will send in a copy of the physical exam then.

☐ My child needs a health care provider/doctor. Please call me at _____.

☐ My child needs health insurance. Please call me at _____.

- **If the form is not returned, the school medical provider (NP, PA, or MD) may proceed with the physical examination per New York State Law.**
- **In-school physical exams include examination of all body systems, similar to a physical examination done in a primary care office.**
- **Your child may refuse the examination. In that case, you will be required to obtain the examination by your own health care provider/doctor.**
- **In-school examinations will not be rescheduled.**

_____ _____

Student's Name **Parent/Guardian Signature**

_____ _____

School **Date**

PLEASE RETURN TO SCHOOL NURSE

SYRACUSE CITY SCHOOL DISTRICT
Anthony Q. Davis, Sr., Superintendent of Schools

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child's doctor.

Student Name: _____ DOB: _____ Date: _____

As the parent/guardian of the child named, the completion of this form authorizes your doctor, to disclose your child's confidential health-related information to his or her school.

The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the child's school. This is important information for many reasons. For example, the school may need to know this information in order to give medications, monitor the child's illness, and keep track of immunizations.

Provider/Practice Name_____

Address_____ Phone Number_____

This authorization limits the disclosure of information to the following:

- ☐ Immunization information
- ☐ Physical exam reports
- ☐ Laboratory tests
- ☐ Medications and treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.

The information will be disclosed to the school in the school district indicated below until you tell us that the child is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the child's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the child's information to their school. The child's healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your child treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. Please keep a copy for your records.

_____ _____
Child's Name (print) Date of Birth

_____ _____
Parent/Guardian's Name (print) Relationship

_____ _____
Parent/Guardian's Signature School

Please return to the School Nurse