



# PARENT QUESTIONNAIRE: Child Health

Child's Name (Last, First) :		Date of Birth:	Age:	Sex : M F	Today's Date:
Address:		City:	State:	Zip:	Phone:
Child's Race (circle) : 8=Don't know		3=White	5=American Indian/ Alaskan Native		
2=Black or African American		4=Asian or Pacific Islander	6=Other, specify: _____		
Is your child also Hispanic or Latino (circle) : Yes No		Child's Doctor:			Doctor's Phone:
Name of person completing this form:			Relationship to child:		Phone:

### CHIEF CONCERN:

1. Who suggested this child be seen by the doctor for attention, school, or behavior problems?		
2. What concerns do you have about your child?		
a.		
b.		
c.		
3. How long have you been concerned about this child's behavior?	4. Please circle ONE: Overall, the above concerns are <b>mild, moderate, or severe?</b>	5. Please circle ONE: My concerns are <b>improving, staying the same, or getting worse?</b>
6. Please describe this child's <b>strongest areas at home:</b>	7. Please describe this child's <b>weakest areas at home:</b>	
a.	a.	
b.	b.	
c.	c.	

### HISTORY: Birth

1. How much did this child weigh at birth? ___pounds ___ounces		4. Number of <b>pregnancies prior</b> to this child: _____	
2. Biological <b>Father's age</b> at birth of this child: _____		5. Number of <b>miscarriages prior</b> to this child: _____	
3. Biological <b>Mother's age</b> at birth of this child: _____			
Y	N	6. Were there any <b>problems during the pregnancy?</b> Specify:	
Y	N	7. Were there any <b>problems during labor / delivery or following the birth?</b> Specify:	
Y	N	8. Was this child born by <b>Cesarean / C-Section?</b> If yes, circle appropriate response: <b>planned emergency</b>	
Y	N	9. Was this child born <b>two or more weeks before</b> the "due date"? If yes, how many weeks early was this child? _____ weeks	
Y	N	10. Were any substances or <b>medications used by the mother</b> during the pregnancy?	
		___ Beer / Wine	___ Alcohol
		___ Tobacco	___ Marijuana
		___ Any prescription medication	___ Methamphetamine (Crystal / Ice)
		___ Cocaine	___ Other: _____
Y	N	11. Were any substances or <b>medications used by the father</b> around the time this child was conceived?	
		___ Beer / Wine	___ Alcohol
		___ Tobacco	___ Marijuana
		___ Any prescription medication	___ Methamphetamine (Crystal / Ice)
		___ Cocaine	___ Other: _____

### \*HISTORY: Developmental Concerns

Y	N	1. Did this child <b>sit up</b> by 8 months?
Y	N	2. Did this child <b>crawl</b> by 10 months?
Y	N	3. Did this child <b>walk</b> by 15 months?
Y	N	4. Did this child <b>speak 2 word sentences</b> by 2 years?
Y	N	5. Could strangers <b>understand</b> this child by 3 years?
Y	N	6. Did this child <b>stay dry during the day</b> by 3 ½ years?
Y	N	7. Did this child <b>read simple words</b> by 6 years?

(OFFICE USE ONLY) Y=[concern ≥6 months: Y N Birth: Y N ] \*N=[Development: Y N ]



## PARENT QUESTIONNAIRE: Child Health

<b>Child's Name:</b>			
Y	N	1. Did this child <b>cry frequently</b> as an infant?	
Y	N	2. Was this child <b>difficult to calm</b> down as an infant?	
Y	N	3. Did this child <b>have trouble sleeping</b> as an infant (e.g., was this child fidgety or overly sleepy)?	
Y	N	4. Was this child a <b>picky or irregular eater</b> as an infant?	
Y	N	5. Did this child have <b>many temper tantrums</b> as a toddler?	
Y	N	6. Did you have <b>trouble keeping a babysitter</b> because of this child's behavior?	
Y	N	7. Does this child have <b>urine accidents</b> ?	
Y	N	8. Does this child have <b>stool / bowel accidents</b> ?	
Y	N	9. Does this child often have <b>nightmares</b> ?	
Y	N	10. Has this child ever had <b>tics or nervous twitches</b> , such as repeated eye blinking, head jerking, or throat clearing?	
Y	N	11. Does this child have any <b>problems falling asleep</b> ? Specify:	
Y	N	12. Does this child have any <b>problems staying asleep</b> through the night? Specify:	
Y	N	13. Does this child have any <b>problems getting up</b> in the morning? Specify:	
Y	N	14. Does this child have <b>frequent stomachaches and headaches</b> ? Specify:	
Y	N	15. Does this child have <b>problems with his/her weight</b> ? Specify:	
<b>HISTORY: Health</b>			
Y	N	1. Has this child had any <b>major health problems</b> ? Specify:	
Y	N	2. Has this child had frequent <b>ear infections</b> ?	
Y	N	3. Has this child had any <b>vision / eye or hearing</b> problems? Specify:	
Y	N	4. Has this child ever been <b>hospitalized</b> or had <b>surgery</b> ? Specify:	
Y	N	5. Has this child lost <b>consciousness</b> or had a <b>serious head injury</b> ? Specify:	
Y	N	6. Has this child had <b>meningitis</b> or <b>encephalitis</b> ? Specify:	
Y	N	7. Has this child had <b>seizures</b> ?	
Y	N	8. Has this child had any <b>difficulties with growth</b> ? Specify:	
Y	N	9. Does this child have any <b>birth defects</b> or <b>birthmarks</b> ? Specify:	
<b>HISTORY: Family Medical Problems:</b>		Is there anyone in this child's family with the following:	
Y	N	Don't Know	1. Neurologic problems
Y	N	Don't Know	2. Learning or reading difficulty
Y	N	Don't Know	3. Depression
Y	N	Don't Know	4. Bipolar Disorder / Manic Depression
Y	N	Don't Know	5. Schizophrenia
Y	N	Don't Know	6. History of physical or sexual abuse
Y	N	Don't Know	7. Alcohol or Drug problems
Y	N	Don't Know	8. ADHD / ADD (attention problems)
Y	N	Don't Know	9. Tics or Tourette's disorder
Y	N	Don't Know	10. Trouble with the law
Y	N	Don't Know	11. Medications for nerves or emotional problems
Y	N	Don't Know	12. Thyroid problems
Y	N	Don't Know	13. Exposure to toxic chemicals
Y	N	Don't Know	14. Cardiac problems or sudden death?
<small>(OFFICE USE ONLY</small>		<small>Behavior: Y N</small>	<small>Health: Y N</small>
		<small>Family Medical History: Y N</small>	<small>If yes, how is this person related to this child?</small>
<small>Baseline: Tics: Y N</small>		<small>Sleep Problems: Y N</small>	<small>Stomachache/Headache: Y N</small>
		<small>Weight: Y N</small>	

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## PARENT QUESTIONNAIRE: Child Health

<b>Child's Name:</b>														
<b>HISTORY: Child's Past/Current Treatment</b>														
<b>Y</b>	<b>N</b>	1. Has this child ever been diagnosed with <b>ADHD or ADD in the past?</b> If yes: Year ____ Month ____												
<b>Y</b>	<b>N</b>	2. Has this child ever taken medication for <b>ADHD or ADD in the past?</b> If yes, do you know the <b>name, dose, and time(s) of day</b> the medication was given?												
		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; border: 1px solid black;"><b>a. Name</b></td> <td style="width: 20%; border: 1px solid black;"><b>Dose</b></td> <td style="width: 35%; border: 1px solid black;"><b>Time(s) of Day</b></td> </tr> <tr> <td style="border: 1px solid black;"><b>b.</b></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> </tr> </table>	<b>a. Name</b>	<b>Dose</b>	<b>Time(s) of Day</b>	<b>b.</b>								
		<b>a. Name</b>	<b>Dose</b>	<b>Time(s) of Day</b>										
		<b>b.</b>												
c. Were you <b>satisfied</b> with the medication's effect on this child's symptoms? (circle) <b>Yes</b> <b>No</b>														
3. Has this child ever received <b>psychological counseling</b> for any problems? Specify:														
<b>Y</b>	<b>N</b>	4. Has this child ever been on any <b>long-term medications?</b> Specify:												
<b>Y</b>	<b>N</b>	5. Does this child have any <b>allergies?</b> Specify:												
<b>Y</b>	<b>N</b>	6. Is this child currently taking any <b>medications?</b>												
<b>Y</b>	<b>N</b>	7. Is this child currently taking any <b>vitamins or herbal supplements?</b>												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; border: 1px solid black;"><b>Name</b></td> <td style="width: 20%; border: 1px solid black;"><b>Dose</b></td> <td style="width: 35%; border: 1px solid black;"><b>Time(s) of Day</b></td> </tr> <tr> <td style="border: 1px solid black;"><b>a.</b></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> </tr> <tr> <td style="border: 1px solid black;"><b>b.</b></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> </tr> <tr> <td style="border: 1px solid black;"><b>c.</b></td> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;"></td> </tr> </table>			<b>Name</b>	<b>Dose</b>	<b>Time(s) of Day</b>	<b>a.</b>			<b>b.</b>			<b>c.</b>		
<b>Name</b>	<b>Dose</b>	<b>Time(s) of Day</b>												
<b>a.</b>														
<b>b.</b>														
<b>c.</b>														
9. <b>Are there any professionals</b> (such as doctors, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) <b>currently involved in this child's care? Please list them and their role in your child's care:</b>														
<b>HISTORY: Social</b>														
<b>Y</b>	<b>N</b>	1. Have there been any <b>major changes or stresses</b> in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet)? If yes, please specify and include how old the child was at the time:  Is this stress still occurring? (circle) <b>Yes</b> <b>No</b>												
<b>Y</b>	<b>N</b>	2. Has there been a <b>serious illness or death</b> in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:												
<b>Y</b>	<b>N</b>	3. Has this child <b>experienced or seen any traumatic events</b> (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your doctor? If yes, please specify and include how old the child was at the time:  Is this trauma still occurring? (circle) <b>Yes</b> <b>No</b>												
<b>Y</b>	<b>N</b>	4. Are any <b>major changes or stresses</b> expected in the future? If yes, please specify:												
(OFFICE USE ONLY)      Adhd Dx: Y    N      Adhd Tx: Y    N      Medications: Y    N      Professionals: Y    N      Social: Y    N														

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<b>Child's Name:</b>					
<b>1. This child is currently living with</b> (please check one)					
<input type="checkbox"/> Biological mother <b>and</b> biological father <input type="checkbox"/> Biological mother <input type="checkbox"/> Biological father <input type="checkbox"/> Relative (specify relationship):	<input type="checkbox"/> Adoptive parent(s), relative Does this child know that he / she is adopted? (circle) Yes No <input type="checkbox"/> Adoptive parent(s), non-relative Does this child know that he / she is adopted? (circle) Yes No <input type="checkbox"/> Foster parent(s) How long has this child been in foster care? Year_____ Month_____ How long has this child been living in your household? Year_____ Month_____ <input type="checkbox"/> Other (specify):				
<b>2. The biological parents of this child are currently</b> (please check one):					
<input type="checkbox"/> Married to each other Year_____ Month_____ <input type="checkbox"/> Divorced from each other Year_____ Month_____ <input type="checkbox"/> Separated from each other Year_____ Month_____ <input type="checkbox"/> Never married to each other	<input type="checkbox"/> Other (please specify): <input type="checkbox"/> Not Applicable (please specify): <input type="checkbox"/> Don't Know				
<b>3. How would you describe the current relationship between this child's biological parents:</b>					
<input type="checkbox"/> Friendly / Amicable <input type="checkbox"/> Unfriendly / Conflict ridden <input type="checkbox"/> No relationship	<input type="checkbox"/> Not Applicable (please specify): <input type="checkbox"/> Don't Know				
Y	N	<b>4. Are there any immediate family members</b> who do not live with this child (biological mother, biological father, or siblings)? If yes, please specify relationship to child:			
Y	N	<b>5. Is there anything unusual about this child's living arrangement</b> that you would like to discuss with the child's doctor? If yes, please specify:			
Y	N	<b>6. Are the parent(s)/guardian(s) of this child working outside of the home?</b>			
Y	N	<b>7. Do you have family or social support locally?</b>			
<b>8. Please list all people who are currently living in this child's household.</b>					
<b>Name</b>	<b>Relationship to Child</b>	<b>Age</b>	<b>Name</b>	<b>Relationship to Child</b>	<b>Age</b>
Y	N	<b>1. Are you or another parent/guardian of your child currently in the Military?</b>			
Y	N	<b>2. What Branch:</b> Navy Marine Air Force Army Other (specify):			
Y	N	<b>3. Are any of this child's parent(s)/guardian(s) Active Duty Military?</b> If yes, who (circle): Mother Father Both Other:			
Y	N	<b>4. Are they deployed or deployable?</b>			
		<b>5. When did you PCS/Move to this Location?</b> Date:			
		<b>6. When are you due to PCS / Move?</b> Date:			
Y	N	<b>7. Do you live in military housing?</b>			
Y	N	<b>8. Is this child or other members of this family in the Exceptional Family Member Program?</b>			
(OFFICE USE ONLY) Living Arrangement: Y N					

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## PARENT QUESTIONNAIRE: Child Health

Child's Name: \_\_\_\_\_

Check the box that best describes your child's behavior over the past 6 months. If your child is currently taking medication, please rate your child's behavior **NOT** on medication.

Never Rarely 0	Occa- sionally 1	Often 2	Very often 3
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1. <b>Fails to give close attention</b> to detail or <b>makes careless mistakes</b> (e.g., homework).			
2. Has <b>difficulty attending</b> to what needs to be done.			
3. <b>Does not seem to listen</b> when spoken to directly.			
4. <b>Does not follow through</b> when given directions.			
5. Has <b>difficulties organizing</b> tasks and activities.			
6. <b>Avoids, dislikes,</b> or does not want to start tasks.			
7. <b>Loses things</b> necessary for tasks or activities (school assignments, pencils, books).			
8. Is <b>easily distracted</b> by noises or other things.			
9. Is <b>forgetful</b> in daily activities.			
10. <b>Fidgets</b> with hands or feet or squirms in seat.			
11. <b>Leaves seat</b> when he/she is supposed to stay in seat.			
12. <b>Runs about or climbs</b> too much when he/she is supposed to stay seated.			
13. Has <b>difficulty playing</b> or starting quiet games.			
14. Is <b>"on the go"</b> or acts as if "driven by a motor".			
15. <b>Talks too much.</b>			
16. <b>Blurts out answers</b> before questions have been completed.			
17. Has <b>difficulty waiting his/her turn.</b>			
18. <b>Interrupts</b> or bothers others when they are talking or playing games.			
19. <b>Argues</b> with adults.			
20. <b>Loses temper.</b>			
21. Actively <b>disobeys or refuses</b> to follow adult's request or rules.			
22. <b>Bothers people</b> on purpose.			
23. <b>Blames others</b> for his or her mistakes or misbehaviors.			
24. Is <b>touchy or easily annoyed</b> by others.			
25. Is <b>angry or bitter.</b>			
26. Is <b>hateful</b> and wants to get even.			
27. <b>Bullies,</b> threatens, or scares others.			
28. <b>Starts physical fights.</b>			
29. <b>Lies</b> to get out of trouble or to avoid jobs (i.e. "cons" others).			
30. <b>Skips school</b> without permission.			
31. Is <b>physically unkind</b> to people.			
32. Has <b>stolen things</b> that have value.			
33. <b>Destroys others' property</b> on purpose.			



## PARENT QUESTIONNAIRE: Child Health

<b>Child's Name:</b>				
Check the box that best describes your child's behavior over the past 6 months. <i>If your child is currently taking medication, please rate your child's behavior NOT on medication.</i>	Never Rarely 0	Occa- sionally 1	Often 2	Very often 3
34. Is physically <b>mean to animals</b> .				
35. Has <b>set fires</b> on purpose to cause damage.				
36. Has <b>broken into</b> someone else's home, business, or car.				
37. Has <b>stayed out all night</b> without permission or <b>runaway</b> from home overnight.				
38. Has <b>used a weapon</b> that can cause serious physical harm (e.g. bat, broken bottle, brick).				
39. Is <b>fearful, anxious, or worried</b> .				
40. Is <b>afraid to try new things</b> for fear of making mistakes.				
41. Feels <b>useless or inferior</b> .				
42. <b>Blames self</b> for problems, feels at fault.				
43. Feels <b>lonely, unwanted, or unloved</b> ; complains that "no one loves me."				
44. Is <b>sad or unhappy</b> .				
45. Feels <b>different and easily embarrassed</b> .				
46. Is <b>overly concerned about health/body</b> .				
47. Has problems getting along with <b>you</b> .				
48. Has problems getting along with <b>others his/her own age</b> .				
49. Has problems getting along with <b>his / her own siblings</b> .				
50. Has problems in <b>group activities</b> such as games or team play.				
51. <b>Decreased interest or pleasure in all</b> , or almost all, activities of the day.				
52. Has <b>said things like "I wish I were dead"</b> or has tried to hurt self.				
53. <b>Recurrent excessive distress</b> when separation from home or caretakers.				
54. Has <b>distinct periods of unusually irritable or unusually cheerful mood</b> (different from normal).				
55. Has <b>prolonged temper tantrums</b> (greater than 20-30 minutes).				
56. <b>Hears voices</b> others do not hear.				
57. Has <b>compulsions</b> (e.g. child seems driven to wash hands, count, erase until holes appear).				
58. Has <b>obsessions</b> (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
59. Has <b>recurrent recollections or dreams</b> of a traumatic event.				
60. Seems to <b>avoid or have phobias</b> of specific people, animals, things or situations.				
61. Seems <b>unaware of others existence</b> , is <b>uninterested in interacting with others</b> .				
62. Has <b>odd, eccentric or unusual preoccupations</b> (e.g. clothing items, toys, neatness)				
63. Appears <b>uninterested in activities</b> children his or her age usually like or participate in.				
64. Has experimented with or abused <b>drugs or alcohol</b> .				

(OFFICE USE ONLY) 27—38: \_\_\_/12 Conduct Disorder: ≥ 3/12 39—46: \_\_\_/7 Anxiety/Depression: ≥ 3/7 47—50: \_\_\_/4 Social Functioning: ≥ 1/4 51—64: \_\_\_/14 Mental Health Concerns

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## PARENT QUESTIONNAIRE: Child Health

Child's Name:	Length of time at present school:	Current Grade:
Name of School:	School District:	
Teacher (main):	Principal:	School Phone:

1. Please describe this child's <b>strongest</b> areas in his/her <b>schoolwork</b> : a. b. c.	2. Please describe this child's <b>weakest</b> areas in his/her <b>schoolwork</b> : a. b. c.
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HISTORY: School Intervention		
Y	N	1. Has this child been in an <b>Early Intervention program or Special Day Care/Preschool</b> ?
Y	N	2. Has this child had <b>speech, occupational or physical therapy</b> ?
Y	N	3. Has this child ever <b>attended summer school</b> ? If Yes, specify subject(s) / grade(s)?
Y	N	4. Has the school ever <b>discussed this child attending summer school</b> with you? Specify:
Y	N	5. Has this child ever <b>repeated a grade</b> ? If Yes, specify subject(s) / grade(s)?
Y	N	6. Has the school ever <b>discussed this child repeating a grade</b> with you? Specify:
Y	N	7. Is there a possibility that <b>current grade or subjects will need repeating</b> ? Specify:
Y	N	8. Has this child ever received any <b>special education services</b> (like a 504 Plan or IEP)? Specify:
Y	N	9. Is this child <b>currently receiving any special education services</b> (like a 504 Plan or IEP)? Specify:
Y	N	10. Have any <b>disciplinary actions</b> been taken (detentions, suspension, or expulsion)? Specify:
Y	N	11. Does this child need any <b>special medical assistance</b> ? Specify:

HISTORY: School Problems			For each of the following grades this child has completed, were any <b>problems reported</b> ? If Yes, please <b>describe</b> the teacher or parent concerns in the space provided.			
			Academics	Behavior		
Y	N	1. Preschool				
Y	N	2. Kindergarten and First Grade				
Y	N	3. Second and Third Grade				
Y	N	4. Fourth and Fifth Grade				
Y	N	5. Sixth through Eighth Grade				
Y	N	6. High School				

CURRENT: School Performance												Please circle the appropriate number.				
		Above Average	Average	Problematic				Above Average	Average	Problematic						
1. Classroom Assignment Completion	1	2	3	4	5	8. Science	1	2	3	4	5					
2. Homework Completion	1	2	3	4	5	9. Written Expression	1	2	3	4	5					
3. Getting Homework to and from school	1	2	3	4	5	10. Handwriting	1	2	3	4	5					
4. Organizational Skills	1	2	3	4	5	11. Social Studies/History	1	2	3	4	5					
5. Reading	1	2	3	4	5	12. Art	1	2	3	4	5					
6. Spelling	1	2	3	4	5	13. Other:	1	2	3	4	5					
7. Mathematics	1	2	3	4	5											

(OFFICE USE ONLY) School Intervention: Y N Academic School Problems: Y N Behavior School Problems: Y N School Performance: Y N

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**PARENT QUESTIONNAIRE: Child Health**

Nursing & Wellness Program

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOLS**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

**USE AND DISCLOSURE INFORMATION:**

Patient/Student Name: \_\_\_\_\_ / \_\_\_\_\_  
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of health care provider, health plan and/or agency):

(1) \_\_\_\_\_ (2) \_\_\_\_\_  
to provide health information from the above-named child's medical record to and from:

\_\_\_\_\_  
School to Which Disclosure is Made Address / City and State / Zip Code  
\_\_\_\_\_  
Contact Person at School District Telephone and Fax Number

Disclosure of health information is required for the following purpose: learning, behavior & attention

Requested information shall be limited to the following:  All minimum necessary health information; or  
 Disease-specific information as described: All information related to learning, behavior and attention.

**DURATION:**

This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date)  
or for one year from the date of signature, if no date entered.

**RESTRICTIONS:**

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

**YOUR RIGHTS:**

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

**RE-DISCLOSURE:**

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: \_\_\_\_\_  
Printed Name Signature Date

\_\_\_\_\_  
Relationship to Patient/Student Area Code and Telephone Number