BALDWINSVILLE CENTRAL SCHOOL DISTRICT □ 29 EAST ONEIDA STREET □ BALDWINSVILLE, NY 13027

MEDICAL REQUEST FOR ALTERNATE INSTRUCTION

THIS SECTION TO BE COMPLETE BY THE ATTENDING PHYSICIAN

STUDENT INFORMATION

Date of Birth: _____

_____ Is under my care for _____

(Student's Name– please print) (Diagnosis)

_____ _____

Name of School Attending Grade Level

What limitations does this diagnosis cause? (e.g., severely limits ambulation)

_____

_____

How does this limitation affect the student's ability to attend school? (e.g., increased risk of fractures.)

_____

_____

Please select mode of Instruction: ☐ 3 to 5 Program (instruction at after school program) (**This option applies to grades 8 – 12 only**) ☐ Modified Schedule (half day)

In keeping with medical accommodations which prevent a student from attending public school, while a student is receiving alternate instruction, work permits will not be issued and extracurricular activity, field trip participation, and other school sponsored events (dances, athletic competitions, fine arts and club activities, etc.) are prohibited.

Alternative instructional services are contingent upon a physician's authorization for a specified period of time **not to exceed 30 days**. Student will be expected to return to school at the end of the specified duration listed below by the physician. If continuation of services will be required for a student, the physician's authorization must be presented to the district **before** the end date listed below.

Physician's Additional Comments (please attach additional sheets as needed)

_____

I hereby certify that it is appropriate for my patient, _____ ____, to receive alternate instruction as described above due to the inability to attend school **beginning** _____ and **ending** on _____. **(Maximum 30 calendar days for each physician request.)**

I can be reached at the following contact numbers: Office ( ) _____ Beeper ( ) _____

On Monday _____ (hrs); Tuesday _____ (hrs); Wednesday _____ (hrs); Thursday _____ (hrs); Friday _____ (hrs)

Provider's Original Signature _____ License#: _____

Print Name / Degree _____ Date: _____

Provider's Address _____

USE AND DISCLOSURE INFORMATION to be completed by Parent or Guardian of Student:

Patient/Student Name _____ _____

Last First Middle Initial Date of Birth

I, the undersigned, do hereby authorize the healthcare provider listed above to provide health information for the above named child's medical record to and from: Baldwinsville Central School District's medical office, school nurse, guidance counselor and/or school principal to assess the impact of the medical condition(s) as it relates to school programming and/or attendance.

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 is provided.

YOUR RIGHTS:

- ☐ I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.
- ☐ I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected health Information before receiving my written revocation notice.
- ☐ I understand that any Protected Health Information disclosed as a result of the Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.
- ☐ I understand that my child's treatment is not dependent on my agreement to release or withhold information.

_____ _____ _____

Date Signature of Patient (over 18), parent, or guardian Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Rev. 7/17/2013