CADDO PARISH PUBLIC SCHOOLS
Attendance & Census Department
P. O. Box 32000 • Shreveport, Louisiana 71130-2000
(318) 603-6303 Office • (318) 424-8187 FAX

PHYSICIAN'S QUESTIONNAIRE for MEDICAL TRANSFER REQUEST

STUDENT NAME: _____

Parent(s)/Legal Guardian: _____
Signature of Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status)

DATE: _____

RESTRICTIONS: This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in this health record may include information relating to behavioral or mental health services. This information may be disclosed and used by the following organization. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Director of Child Welfare and Attendance. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

The Caddo Parish School Board is obligated to follow the guidelines of the Consent Decree of 1981, Civil Action Number 11,055. It provides that medical transfers can be granted ONLY for students whose attendance at a particular school is detrimental to his/her medical condition. Information should be provided for each item and should be as concise and specific to the transfer request as possible. Only a Physician, Physician Assistant, or Nurse Practitioner is authorized to complete this form with all information to be confirmed.

(OVER)

1. **<u>Medical condition(s) for which treatment has been sought / given:</u>** Please describe disabilities and/or limitations the student has: _____

_____

_____

_____

2. Date student was first seen for this condition: _____

3. Since that time, the student has sought medical attention:
____regularly ____sometimes ____rarely ____not at all

4. Date student was last seen for this condition: _____

5. What factors **<u>within the assigned district school</u>** are detrimental to the health of the student that **prevents him/her from attending their district school?**

_____

_____

_____

_____

_____

_____
Physician, PA, NP Name (Please Print)

I attest that the foregoing information is true to the best of my knowledge.

_____
Address

_____
Physician, PA, NP Signature

_____
Telephone Number

_____
Date