

CADDO PARISH PUBLIC SCHOOLS

Attendance & Census Department

1961 Midway Avenue • Shreveport, Louisiana 71108

(318) 603-6305 Office • (318) 424-8187 FAX

MEDICAL TRANSFER REQUEST

Student Name: _____ **Date:** _____

This page must be completed by Parent/Legal Guardian; both pages given to Medical Provider and both pages returned for consideration of Medical transfer request:

Current Caddo District School: _____

Requested Caddo School: _____

Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian (proof of Legal Guardianship required)

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 requesting 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 and 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 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.

Student: _____

DOB: _____

Please Print

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

2. Date student first seen for this condition: _____
3. Since first seen, the parent/legal guardian has sought medical attention for the student:
 ____regularly ____sometimes ____rarely ____not at all
4. Date student was last seen for this condition: _____
5. What factors **within the assigned district school** are detrimental to the health of the student that **prevents him/her from attending their district school?**
***NOTE:** all students experiencing medical emergencies will be transported to the local Trauma Center and stabilized prior to transport to the hospital of choice for the parent/legal guardian.*

Physician, PA, CNP Name (Please Print)

Office Number

Physician, PA, CNP Signature

Office Address

Date

Office Fax Number