5119.6 MEDICAL AND/OR HEALTH REQUEST PACKET

Dear Parent/Guardian:

The following steps are for a transfer/reassignment request for medical and/or health reasons of the student.

1) Submit an online request for Reassignment/Transfer Application for a medical and/or health reason. You will need to have your student's medical doctor complete the Medical and/or Health Request Packet.

2) You may submit up to three additional pages of comments or information with your Medical and/or Health Request Packet. Information submitted over the three page limit will be retained in the Student Placement Office and not forwarded to the Medical Review Committee. The additional pages should be sent to the Student Placement Office at the address below or sent by fax to 980-343-5661.

3) Complete the Authorization for Medical Records and Reports (page 2 of the packet).Your student's medical doctor needs to complete the Physician Statement (page 3 of the packet) and return both the Authorization page and Physician Statement page to the Student Placement Office at our address below or by fax to 980-343-5661.

4) Your student's entire packet will be sent to a committee of physicians who will review your request. This committee will make a recommendation to the school system based on the medical situation. This recommendation becomes part of the information used to either approve or deny your request to change your student's school assignment.

Due to additional steps involved in this process, please allow up to 8 weeks for a notification letter from the Student Placement Office.

Student Placement Office
Charlotte-Mecklenburg Schools
1901 Herbert Spaugh Lane
Charlotte NC 28208

If you have any questions about the process, contact the Student Placement Office at 980-343-5335.

CHARLOTTE-MECKLENBURG SCHOOLS

AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS

DATE: _____

TO: _____
Name of student's physician or medical group

You, and any person associated with you and your practice, are hereby authorized to release to the Charlotte-Mecklenburg Board of Education and to a duly appointed Student Reassignment Request Review Committee of area health professionals, or any representatives thereof, any and all information which may be requested concerning the physical, mental, emotional or other medical treatment rendered by you therefore to:

_____
(Name of student)

And, if necessary, to allow the Board of Education and/or the review committee to examine any x-ray pictures taken of said student or records that you may have concerning the condition or treatment of said student.

You are hereby advised that any information released hereunder will be used solely in connection with the student reassignment request submitted for said student and for no other purpose. You are further requested to disclose no information to any other person without written authority from me to do so and pursuant to privilege and confidential communication statutes. All prior authorizations are hereby cancelled. This authorization will expire one year from the date of signing.

_____
Printed name of parent/guardian

_____
Signature of parent/guardian

_____
Signature of student if 18 years or older

CHARLOTTE-MECKLENBURG SCHOOLS

MEDICAL FORM

Student's Name _____ Date of Birth _____

PARENT SECTION

You are requesting a:

- (•) CMS Virtual School
  - Is your child eligible for the vaccine?
    - ( ) Yes
    - ( ) No
  - If yes, is your child vaccinated?
    - ( ) Yes
    - ( ) No
- ( ) Other CMS School

MEDICAL / MENTAL HEALTH PROVIDER SECTION

Student's Medical Diagnosis: _____

1. Is the Medical Diagnosis:

- [ ] Chronic: the condition makes it medically necessary for the patient to have treatment visits at least twice per year. EX: asthma
- [ ] Mental Health/Developmental: related to anxiety, ADHD, autism, depression or eating disorder
- [ ] Permanent or Long Term: due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided). EX: cancer
- [ ] Requires Multiple Treatments: Is it medically necessary for the patient to receive multiple treatments over a period of time. EX: chemotherapy treatments

If one or more of the above are checked, an explanation must be provided (please attach additional documentation is more space is needed).

_____

_____

_____

_____

2. What is the student's ability to be responsible for the care of this medical condition?

- (•) Self-sufficient
- ( ) Dependent on adults

CHARLOTTE-MECKLENBURG SCHOOLS

MEDICAL FORM

3. Due to the student's medical diagnosis, is it medically necessary for the student to have a specific school setting?

- ○ Yes
- ◉ No

If yes is answered above, please describe the necessary school conditions / environment to support the student's medical / health needs (please attach additional documentation if more space is needed).

_____

_____

_____

_____

4. How would the student's health condition be affected at the current school of assignment? (Please attached additional documentation if more space is needed)

_____

_____

_____

5. How would the student's health condition be affected at the requested school of assignment? (Please attached additional documentation if more space is needed)? (e.g., proximity to treatment)

_____

_____

_____

6. Comment on the child's medical diagnosis and any accommodations medically needed for this student in a school setting?(Please attached additional documentation if more space is needed)

_____

_____

_____

CHARLOTTE-MECKLENBURG SCHOOLS

MEDICAL FORM

_____

Printed Name of Medical or Mental Health Provider

_____ _____

Signature of Medical or Mental Health Provider Date

I am the:

- ◯ MD
- ◯ DO
- ◯ NP
- ◯ PA
- ◉ LCSW
- ◯ Other _____

_____

_____

_____

Office Mailing Address

_____

Office Telephone Number

_____

Office Fax Number