Rowan-Salisbury
SCHOOL SYSTEM
Extraordinary Education Every Day

Medical Request Information Packet

Dear Parent/Guardian:

1. Complete the appropriate student reassignment request.
2. Complete the Authorization for Release of Medical Information form (included in this packet). This form will give permission for the medical records. To be reviewed, if deemed necessary in the processing of your request.
3. Have your child's medical doctor complete the Physician's Statement Regarding Student Reassignment Request.
4. Return all documents to the location indicated in the directions on the student reassignment form.

Due to the additional review time needed for medical conditions, processing time may be longer than usual.

If you have any questions concerning the process, please contact the Enrollment Specialist at 704-630-6034.

Authorization for Release of Medical Information

Date: _____

To: Student's physician or medical group

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

You and any member of this medical group, are authorized to release to the Rowan-Salisbury Board of Education and to a rightfully appointed Enrollment Specialist and/or Superintendent Designee, any and all information which may be requested concerning the physical, mental, emotional or other medical treatment rendered by you regarding:

_____

(Student's Name)

Any information released will be used solely for the deliberation surrounding the student reassignment request for the above-named student and for no other purpose. This authorization is solely for the specified institution and individual(s) named above. 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

In compliance with federal law, the Rowan-Salisbury School System administers all education programs, employment activities and admissions without discrimination because of race, religion, national or ethnic origin, color, age, military service, disability, or gender, except where exemption is appropriate and allowed by law.

Physician's Statement Regarding School Reassignment Request

Student Name: _____ Date of Birth: _____

The parent/guardian of the above-named student has requested a school reassignment based on medical reasons from:

_____ School to _____ School

Medical Diagnosis:_____
Please answer the following questions by circling the most appropriate response (1 is lowest-5 is highest):
Is the problem: well established < 1 2 3 4 5 > newly diagnosed?
Is the condition: stable < 1 2 3 4 5 > unstable?
Is the student's ability to be responsible for the care of the problem: self-sufficient <1 2 3 4 5 > dependent on adults?
What is your level of medical concern About this child's school assignment: no or little concern < 1 2 3 4 5 > very concerned?
REQUIRED: Comment on the child's condition and how it affects the school assignment (please print):

_____

_____

_____

_____

_____ _____

Signature of Physician Date

_____ _____

Print Name of Physician

Parent/Guardian: Please return this packet with your transfer application before the deadline.

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