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
Family Application Center
1600 Tyvola Road
Charlotte, NC 28210

If you have any questions about the process, contact the Student Placement Office at 980-343-5335 or student.placement@cms.k12.nc.us.

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 ord older

CHARLOTTE-MECKLENBURG SCHOOLS

PHYSICIAN STATEMENT FOR SCHOOL REASSIGNMENT REQUEST

Student's Name _____ Date of Birth: _____

The parent/guardian of the above named student has requested a school reassignment from _____ School to _____ School for medical or health reasons.

Under the guidelines established by the Board of Education which govern student reassignments, a student may be transferred from the school of original assignment if it can be determined that attendance at this school will endanger or be injurious to the health of the student. Medical information from you is needed in order to assist the area health professionals serving on the committee appointed to make a recommendation to the Charlotte-Mecklenburg Board of Education regarding this request.

Student's Medical Diagnosis: _____

Please answer the following four questions by circling the most appropriate response (1-5) on the continuum for each question.
NOTE: All questions revised from earlier forms.

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 this 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):

_____

_____

_____

_____

(use other side if necessary)

_____ Signature of Physician

_____ Date

_____ Office Telephone Number

_____ Print Name of Physician

_____ Office Mailing Address or Fax Number

Thank you for your assistance. If you have any questions about this packet or the reassignment request, please contact the Student Placement Office at 980-343-5335. Please return this packet directly to:

Student Placement Office
Charlotte-Mecklenburg Schools
Family Application Center
1600 Tyvola Road
Charlotte, NC 28210
Fax: 980-343-5661