MEDICAL RELEASE, REFERRAL AND FOLLOW-UP FORM

Person Referring ______________________ Referral Date ____________

I. GENERAL INFORMATION

Student: ______________________ DOB ____________ Age: ______

Address: ______________________ Phone: ____________ Sex: ☐ M ☐ F

School: ______________________ Grade ______ Primary Language: ____________

II. REASON FOR REFERRAL: (Check all that apply)

☐ **Academic Concerns, poor achievement**

☐ **Behavioral Concerns**
- ☐ With peer group
- ☐ In family
- ☐ Self Harm
- ☐ In school
- ☐ In the community

☐ **Family Issues**
- ☐ Communications
- ☐ Behavior Management
- ☐ Conflict
- ☐ Divorce

☐ **Attendance**

☐ **Substance Abuse**

☐ **Gender Issues**

☐ **Cultural Issues**

☐ **Trauma**
- ☐ Assault/Abuse
- ☐ Crisis reaction
- ☐ Grief

☐ **Other:** (including physical, social, family issues)

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☐ **Eating Disorder**

☐ **Attention Deficit Issues**

III. CONSENT

I consent to communication and exchange of information between ______________________ and ______________________ to discuss and share records/conditions pertaining to the above.

I understand that this information is generally confidential and may not be given to employees of other schools, public agencies or individual professionals in private practice without my consent.

Parent/Guardian (Student Over 18) Name ______________________ Date ____________

Parent/Guardian (Student Over 18) Signature ______________________

This authorization shall be valid until ____________ (date). Please indicate a date after which no information can be released. If no date is given, authorization is valid for one year from date of signature. This consent is voluntary.

To revoke this consent, send a copy to the referring person above at ______________________

☐ I revoke this consent for communication and exchange of information.

In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable California laws, all personal and health information is private and must be protected.

☐ Copy provided to Signer

IV. FOLLOW-UP BY HEALTH CARE PROVIDER; PLEASE RETURN FORM TO PERSON REFERRING INDICATED ABOVE

Diagnosis: ______________________

Treatment Provided: ______________________

Medication(s): ______________________

Additional referral to ______________________ Reason: ____________

Student needs to be excluded ☐ No ☐ Yes If yes, for how long? ____________

Should school personnel contact medical provider to discuss this student? ☐ No ☐ Yes

Provider Signature: ______________________

Address: ______________________ Phone: ____________