Children's MINNESOTA

**Our Community Clinics**
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

# SCHOOL PROBLEMS EVALUATION
# MEDICAL HISTORY FORM

Child's name: _____

Birthdate: _____ Date form filled out: _____

Your name: _____ Relationship to child: _____

Primary Phone: _____ Secondary Phone: _____

Name of School: _____ Grade: _____

Referred by: _____

Please list the problems with which you want help for your child:

1. _____
2. _____
3. _____

When did these problems begin? _____

What do you hope to get out of this evaluation? _____

_____

_____

Please list any previous evaluations or treatment for the current problems and attach copies if available:

Date Name of Physician, psychologist, agency, or clinic

_____

_____

## SCHOOL

Please describe your child's current classroom placement and services (attach an Individual Educational Plan [IEP] and copies of any school psycho-educational reports if available):

Special Services Time/days per week

_____

_____

_____

Please indicate current classroom interventions:

- ❒ Behavior chart
- ❒ Seating preference
- ❒ Time to think or behavior room
- ❒ Social skills group
- ❒ Other _____

Name: _____ Date of Birth: _____

School performance: What has the school told you about your child's:

Behavior? _____

_____

Work completion? _____

_____

Academic progress? _____

_____

Does your child often bring home work that should have been done during class time? ❒ Yes ❒ No

Handwriting/ neatness: _____

_____

Please describe previous day care, preschool or school problems:

Grade/year School/Center name Problems

_____

_____

_____

_____

_____

## HOME/FAMILY

| Family Member | Name | Years of School/Degree | Occupation |
|---|---|---|---|
| Parent 1 | | | |
| Parent 2 | | | |
| Step Parent 1 | | | |
| Step Parent 2 | | | |

Parents are: ❒ married ❒ separated ❒ divorced ❒ never married

Custody arrangements if applicable: _____

Who lives at home with this child? _____

Please share any history of significant family stressors (e.g. marital, financial, medical, work-related): _____

_____

_____

Briefly describe any behavior or family issues that bother you in regard to this child:

_____

_____

_____

_____

_____

Please describe any conflict surrounding homework: _____

_____

_____

_____

Name: _____ Date of Birth: _____

Please describe behavior management strategies that have been used at home, and how effective are they:

_____

_____

_____

## SOCIAL

Describe any problems your child may have in making and keeping friends: _____

_____

_____

Please describe any aspect of your child's social life that bothers you: _____

_____

_____

List the organized or leisure time activities your child participates in (e.g.., sports, scouts, religious, free time play):

_____

_____

## SELF-ESTEEM

How do you feel these problems are affecting your child's self-esteem? _____

_____

_____

## BEHAVIOR HISTORY:

If your child has experienced any of these behavior problems, please record the ages they occurred.

| BEHAVIOR | NO | YES | AGES |
|---|---|---|---|
| Colic | | | |
| Infant feeding problems | | | |
| Difficulty falling asleep | | | |
| Difficulty staying asleep | | | |
| Excessive crying | | | |
| Tantrums | | | |
| Difficulty being consoled | | | |
| Overactivity or hyperactivity | | | |
| Difficulty keeping to a schedule | | | |
| Difficulty being satisfied or easily bored | | | |
| Thumb sucking | | | |
| Impulsiveness | | | |
| Anxiety, fears, phobias, excessive worry | | | |
| Obsessive or compulsive behaviors | | | |

Name: _____ Date of Birth: _____

## CHILD'S HEART HISTORY:

If your child has experienced any of these medical problems, please record the ages they occurred:

| PROBLEM | NO | YES | IF YES, PLEASE EXPLAIN |
|---|---|---|---|
| Fainting or dizziness during or after exercise | | | |
| Extreme shortness of breath during exercise (without asthma) | | | |
| Extreme fatigue with exercise (different from peers) | | | |
| Palpitations, increased heart rate, extra or skipped beats | | | |
| Rheumatic Fever | | | |
| An unexplained seizure | | | |
| Heart murmur | | | |
| An unexplained, noticeable change in exercise tolerance | | | |
| High Blood Pressure | | | |
| Previously detected Cardiac Disease | | | |

## REVIEW OF SYSTEMS:

If your child has experienced any of these medical problems, please record the ages they occurred:

| MEDICAL PROBLEM | NO | YES | AGES |
|---|---|---|---|
| Food reactions | | | |
| Appetite problems | | | |
| Underweight or overweight | | | |
| Difficulty sleeping | | | |
| Skin rashes – chronic or frequent | | | |
| Hair loss | | | |
| Unusual moles or birthmarks | | | |
| Recurrent or frequent ear infections | | | |
| Hearing loss | | | |
| Visual problems or wears glasses | | | |
| Recurrent tonsillitis | | | |
| Sinus infections | | | |
| Asthma, wheezing, exercise intolerance | | | |
| Bronchitis | | | |
| Pneumonia | | | |
| Stomachaches | | | |
| Diarrhea | | | |
| Constipation | | | |
| Soiled underwear | | | |
| Recurrent vomiting | | | |
| Bloody stools | | | |
| Daytime wetting | | | |
| Bedwetting | | | |
| Menstrual periods Problems | | | |
| Age menstruation started _____ | | | |
| Joint pain or backache | | | |
| Scoliosis | | | |
| Diabetes | | | |
| Seizures or convulsions | | | |
| Headaches | | | |
| Tics, twitches, or involuntary movements or noises | | | |
| Serious head injury or knocked out | | | |
| Other (specify) | | | |

Name: _____ Date of Birth: _____

## BIOLOGICAL FAMILY HISTORY

These problems sometimes run in families. We are interested if anyone in your family other than your child may have any of these. Place an X in the appropriate column for each affected family member. If more than one brother or sister has one of these problems, put an X for each one in the appropriate column.

| BIOLOGICAL FAMILY HISTORY | Child's mother | Child's father | Child's brother(s) | Child's sister(s) | Others (Specify) |
|---|---|---|---|---|---|
| **LEARNING** | | | | | |
| Difficulty with reading | | | | | |
| Difficulty with arithmetic/math | | | | | |
| Difficulty with writing/spelling | | | | | |
| Speech problems | | | | | |
| Held back in school | | | | | |
| Honor student | | | | | |
| Intellectual Disability (Low IQ) | | | | | |
| **BEHAVIOR** | | | | | |
| Hyperactivity/ADD/ADHD | | | | | |
| Behavior problems before age 12 | | | | | |
| Behavior problems as a teenager | | | | | |
| Trouble with law | | | | | |
| Dropped out of high school | | | | | |
| **MENTAL HEALTH** | | | | | |
| Depression/manic depression/bipolar | | | | | |
| Obsessive compulsive disorder | | | | | |
| Anxiety disorder | | | | | |
| Suicide attempted/committed | | | | | |
| Psychiatric hospitalization | | | | | |
| Participated in psychotherapy | | | | | |
| Drug or alcohol abuse | | | | | |
| **MEDICAL/NEUROLOGICAL** | | | | | |
| Seizures or convulsions | | | | | |
| Tics, twitches, or Tourette's syndrome | | | | | |
| Thyroid problems | | | | | |
| High blood pressure | | | | | |
| High cholesterol | | | | | |
| Kidney disease | | | | | |
| Asthma/allergies | | | | | |
| Cancer | | | | | |
| Other | | | | | |

| BIOLOGICAL FAMILY HEART HISTORY | NO | YES | RELATIONSHIP TO CHILD |
|---|---|---|---|
| Sudden, unexpected, unexplained death before age 50 | | | |
| Died suddenly of "heart problems" before age 50 | | | |
| Unexpected fainting or seizures | | | |
| Enlarged Heart: Hypertrophic Cardiomyopathy | | | |
| Dilated Cardiomyopathy | | | |
| Heart Rhythm problems: Long QT Syndrome | | | |
| Short QT Syndrome | | | |
| Brugada Syndrome | | | |
| Catecholaminergic Ventricular Tachycardia | | | |
| Arrhythmogenic Right Ventricular Cardiomyopathy | | | |
| Wolff-Parkinson-White Syndrome | | | |
| Cardiac Arrhythmias (irregular heart beat) | | | |
| Marfan Syndrome | | | |
| Heart attack occurring before age 35 | | | |
| Pacemaker or implanted defibrillator | | | |
| Event requiring resuscitation in family member less than 35 years old | | | |

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# SCHOOL (WORK) EVALUATION INITIAL SELF REPORT

Name: _____ Date of Birth: _____

Today's Date: _____ Your Phone Number: _____

- Please summarize your main concerns: _____
  _____
- When did these difficulties begin? _____
- How has this affected your schoolwork and/or job? _____
  _____
- How has this affected your relationship with your family? _____
  _____
- How has this affected your relationship with your friends, classmates, team members, or coworkers?
  _____
  _____
- Have you been on medication for ADHD, Depression, Anxiety, or Mental Health in the past? ❒ Yes ❒ No
  If yes, when and how treated? _____

**Directions: When completing this form, please think about your behaviors in the past 6 months.**

| SYMPTOMS | NEVER | OCCASIONALLY | OFTEN | VERY OFTEN |
|---|---|---|---|---|
| 1. I do not pay attention to details or make careless mistakes with, for example, homework or other work. | 0 | 1 | 2 | 3 |
| 2. I have difficulty keeping attention to what needs to be done. | 0 | 1 | 2 | 3 |
| 3. I do not seem to listen well when spoken to directly. | 0 | 1 | 2 | 3 |
| 4. I do not follow through when given directions and fail to finish activities. | 0 | 1 | 2 | 3 |
| 5. I have difficulty organizing tasks and activities. | 0 | 1 | 2 | 3 |
| 6. I avoid, dislike, or do not want to start tasks that require ongoing mental effort. | 0 | 1 | 2 | 3 |
| 7. I lose things necessary for tasks or activities (keys, glasses, wallet, important papers or assignments). | 0 | 1 | 2 | 3 |
| 8. I am easily distracted by noises or other stimuli. | 0 | 1 | 2 | 3 |
| 9. I am forgetful in daily activities. | 0 | 1 | 2 | 3 |
| 10. I fidget and squirm a lot. | 0 | 1 | 2 | 3 |
| 11. I have trouble remaining seated when it is expected. | 0 | 1 | 2 | 3 |
| 12. I am restless and agitated | 0 | 1 | 2 | 3 |
| 13. I have trouble engaging in leisurely activities quietly. | 0 | 1 | 2 | 3 |
| 14. I am "on the go" and have a hard time relaxing. | 0 | 1 | 2 | 3 |
| 15. I talk too much. | 0 | 1 | 2 | 3 |
| 16. I blurt out answers before questions have been completed. | 0 | 1 | 2 | 3 |
| 17. I have difficulty waiting my turn in conversations, activities or driving. | 0 | 1 | 2 | 3 |
| 18. I interrupt or intrude in on others' conversations and/or activities. | 0 | 1 | 2 | 3 |

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Name: _____ Date of Birth: _____

| SYMPTOMS | NEVER | OCCASIONALLY | OFTEN | VERY OFTEN |
|---|---|---|---|---|
| 19. I argue with others often. | 0 | 1 | 2 | 3 |
| 20. I lose my temper easily. | 0 | 1 | 2 | 3 |
| 21. I actively defy or refuse to go along with others' requests and/or activities. | 0 | 1 | 2 | 3 |
| 22. I blame others for my mistakes or misbehavior. | 0 | 1 | 2 | 3 |
| 23. I am touchy or easily annoyed by others. | 0 | 1 | 2 | 3 |
| 24. I am angry or resentful. | 0 | 1 | 2 | 3 |
| 25. I am spiteful and want to get even. | 0 | 1 | 2 | 3 |
| 26. I have bullied, threatened, or intimidated others. | 0 | 1 | 2 | 3 |
| 27. I start physical fights. | 0 | 1 | 2 | 3 |
| 28. I lie to get out of trouble or to avoid obligations. | 0 | 1 | 2 | 3 |
| 29. I am physically cruel to people. | 0 | 1 | 2 | 3 |
| 30. I have stolen things that have value. | 0 | 1 | 2 | 3 |
| 31. I have deliberately destroyed others' property. | 0 | 1 | 2 | 3 |
| 32. I have used a weapon that can cause serious harm (bat, knife, brick, gun). | 0 | 1 | 2 | 3 |
| 33. I have been physically cruel to animals. | 0 | 1 | 2 | 3 |
| 34. I have deliberately set fires to cause damage. | 0 | 1 | 2 | 3 |
| 35. I have broken into someone else's home, business, or car. | 0 | 1 | 2 | 3 |
| 36. I have stayed out at night without informing others of my whereabouts. | 0 | 1 | 2 | 3 |
| 37. I have left home overnight without warning. | 0 | 1 | 2 | 3 |
| 38. I have forced someone into sexual activity. | 0 | 1 | 2 | 3 |
| 39. I am fearful, anxious, or worried. | 0 | 1 | 2 | 3 |
| 40. I am afraid to try new things for fear of making mistakes. | 0 | 1 | 2 | 3 |
| 41. I feel worthless or inferior. | 0 | 1 | 2 | 3 |
| 42. I blame myself for problems, feel guilty. | 0 | 1 | 2 | 3 |
| 43. I feel lonely, unwanted, or unloved; complain that "no one loves me". | 0 | 1 | 2 | 3 |
| 44. I am sad, unhappy, or depressed. | 0 | 1 | 2 | 3 |
| 45. I am self-conscious or easily embarrassed. | 0 | 1 | 2 | 3 |

| PERFORMANCE | EXCELLENT | ABOVE AVERAGE | AVERAGE | SOMEWHAT OF A PROBLEM | PROBLEMATIC |
|---|---|---|---|---|---|
| 46. Overall school/work performance | 1 | 2 | 3 | 4 | 5 |
| 47. Reading | 1 | 2 | 3 | 4 | 5 |
| 48. Math | 1 | 2 | 3 | 4 | 5 |
| 49. Writing | 1 | 2 | 3 | 4 | 5 |
| 50. Relationships with parents. | 1 | 2 | 3 | 4 | 5 |
| 51. Relationships with siblings. | 1 | 2 | 3 | 4 | 5 |
| 52. Relationships with peers. | 1 | 2 | 3 | 4 | 5 |
| 53. Relationship with spouse/significant other | 1 | 2 | 3 | 4 | 5 |

**COMMENTS:**

Provider Initials:_____

Children's MINNESOTA



# A Survey from your Healthcare Provider - PHQ 9 – Modified for Teens

**Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.**

| | (0) Not at All | (1) Several Days | (2) More Than Half the Days | (3) Nearly Every Day |
|---|---|---|---|---|
| 1. Feeling down, depressed, irritable, or hopeless? | | | | |
| 2. Little interest or pleasure in doing things? | | | | |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | | | | |
| 4. Poor appetite, weight loss, or overeating? | | | | |
| 5. Feeling tired, or having little energy? | | | | |
| 6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down? | | | | |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | | | | |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual? | | | | |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? | | | | |

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ❒ Yes ❒ No

11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ❒ Yes ❒ No

13. Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt? ❒ Yes ❒ No

FOR OFFICE USE ONLY **Score** _____

Q 12 and Q 13 = Y or TS = ≥ 11

**Date completed:** _____

PLACE PATIENT LABEL HERE

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

# GAD-7

| **Over the last 2 weeks, how often have you been bothered by the following problems?** *(Use "✔" to indicate your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **1.** Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| **2.** Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| **3.** Worrying too much about different things | 0 | 1 | 2 | 3 |
| **4.** Trouble relaxing | 0 | 1 | 2 | 3 |
| **5.** Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| **6.** Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| **7.** Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**(*For office coding: Total Score T*____ = ____ + ____ + ____ )**

_____ Provider initials

Children's MINNESOTA

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# PARENT SCHOOL PROGRESS INITIAL EVALUATION

Child's Name: _____ Date of Birth: _____ Today's Date: _____

Parent's Name: _____ Parent's Phone Number: _____

**Directions:** **Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

| SYMPTOMS | NEVER | OCCASIONALLY | OFTEN | VERY OFTEN |
|---|---|---|---|---|
| 1. Does not pay attention to details or makes careless mistakes with, for example, homework. | 0 | 1 | 2 | 3 |
| 2. Has difficulty keeping attention to what needs to be done. | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen when spoken to directly. | 0 | 1 | 2 | 3 |
| 4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand). | 0 | 1 | 2 | 3 |
| 5. Has difficulty organizing tasks and activities. | 0 | 1 | 2 | 3 |
| 6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort. | 0 | 1 | 2 | 3 |
| 7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books). | 0 | 1 | 2 | 3 |
| 8. Is easily distracted by noises or other stimuli. | 0 | 1 | 2 | 3 |
| 9. Is forgetful in daily activities. | 0 | 1 | 2 | 3 |
| 10. Fidgets with hands or feet or squirms in seat. | 0 | 1 | 2 | 3 |
| 11. Leaves seat when remaining seated is expected. | 0 | 1 | 2 | 3 |
| 12. Runs about or climbs too much when remaining seated is expected. | 0 | 1 | 2 | 3 |
| 13. Has difficulty playing or beginning quiet play activities. | 0 | 1 | 2 | 3 |
| 14. Is "on the go" or often acts as if "driven by a motor". | 0 | 1 | 2 | 3 |
| 15. Talks too much. | 0 | 1 | 2 | 3 |
| 16. Blurts out answers before questions have been completed. | 0 | 1 | 2 | 3 |
| 17. Has difficulty waiting his or her turn. | 0 | 1 | 2 | 3 |
| 18. Interrupts or intrudes in on others' conversations and/or activities. | 0 | 1 | 2 | 3 |
| 19. Argues with adults. | 0 | 1 | 2 | 3 |
| 20. Loses temper. | 0 | 1 | 2 | 3 |
| 21. Actively defies or refuses to go along with adults' requests and/or activities. | 0 | 1 | 2 | 3 |
| 22. Deliberately annoys people. | 0 | 1 | 2 | 3 |
| 23. Blames others for his or her mistakes or misbehavior. | 0 | 1 | 2 | 3 |
| 24. Is touchy or easily annoyed by others. | 0 | 1 | 2 | 3 |
| 25. Is angry or resentful. | 0 | 1 | 2 | 3 |
| 26. Is spiteful and wants to get even. | 0 | 1 | 2 | 3 |
| 27. Bullies, threatens, or intimidates others. | 0 | 1 | 2 | 3 |
| 28. Starts physical fights. | 0 | 1 | 2 | 3 |
| 29. Lies to get out of trouble or to avoid obligations (i.e. "cons" others). | 0 | 1 | 2 | 3 |
| 30. Is truant from school (skips school) without permission. | 0 | 1 | 2 | 3 |
| 31. Is physically cruel to people. | 0 | 1 | 2 | 3 |
| 32. Has stolen things that have value. | 0 | 1 | 2 | 3 |
| 33. Deliberately destroys others' property. | 0 | 1 | 2 | 3 |
| 34. Has used a weapon that can cause serious harm (bat, knife, brick, gun). | 0 | 1 | 2 | 3 |
| 35. Is physically cruel to animals. | 0 | 1 | 2 | 3 |
| 36. Has deliberately set fires to cause damage. | 0 | 1 | 2 | 3 |
| 37. Has broken into someone else's home, business, or car. | 0 | 1 | 2 | 3 |
| 38. Has stayed out at night without permission. | 0 | 1 | 2 | 3 |
| 39. Has run away from home overnight. | 0 | 1 | 2 | 3 |
| 40. Has forced someone into sexual activity. | 0 | 1 | 2 | 3 |

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Name: _____ Date of Birth: _____

| SYMPTOMS | NEVER | OCCASIONALLY | OFTEN | VERY OFTEN |
|---|---|---|---|---|
| 41. Is fearful, anxious, or worried. | 0 | 1 | 2 | 3 |
| 42. Is afraid to try new things for fear of making mistakes. | 0 | 1 | 2 | 3 |
| 43. Feels worthless or inferior. | 0 | 1 | 2 | 3 |
| 44. Blames self for problems, feels guilty. | 0 | 1 | 2 | 3 |
| 45. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”. | 0 | 1 | 2 | 3 |
| 46. Is sad, unhappy, or depressed. | 0 | 1 | 2 | 3 |
| 47. Is self-conscious or easily embarrassed. | 0 | 1 | 2 | 3 |

| PERFORMANCE | EXCELLENT | ABOVE AVERAGE | AVERAGE | SOMEWHAT OF A PROBLEM | PROBLEMATIC |
|---|---|---|---|---|---|
| 48. Overall school performance | 1 | 2 | 3 | 4 | 5 |
| 49. Reading | 1 | 2 | 3 | 4 | 5 |
| 50. Writing | 1 | 2 | 3 | 4 | 5 |
| 51. Mathematics | 1 | 2 | 3 | 4 | 5 |
| 52. Relationships with parents. | 1 | 2 | 3 | 4 | 5 |
| 53. Relationships with siblings. | 1 | 2 | 3 | 4 | 5 |
| 54. Relationships with peers. | 1 | 2 | 3 | 4 | 5 |
| 55. Participation in organized activities (e.g. teams) | 1 | 2 | 3 | 4 | 5 |

**COMMENTS:**



Provider Initials:_____

Children's MINNESOTA

# AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

MRN: _____(*office use only*)

**Children's Minnesota**
**Health Information Management (HIM)**
**5901 Lincoln Drive**
**Mail stop CBC-2-HIM**
**Edina, MN 55436**
**Phone: 952-992-5200**
**Release of Information Fax: 612-813-5980**

**(O*ffice use only*)**
**Staff Initials _____**

**# of pages _____**

**ID Verified: ☐ Yes**
**Comments:**

_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____

How to upload to MyChildren's portal

1. Print and complete this form.
2. Scan or take a photo of your completed form.
3. Log in to your MyChildren's account.
4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management.**

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name _____ Date of Birth _____

**I authorize (release from):**

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

**To release To:** _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

**Purpose of release**: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

**Information needed by (date):** _____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: _____

**Information needed from the following clinics:**
☐Children's Heart Clinic ☐Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐Other:_____

☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

**Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal ☐ MyChildren's**

**☐ Email_____(HIM only)**

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
  I don't want the following records released: _____.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

* R O I *

Children's MINNESOTA

# AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

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**Health Information Management (HIM)**
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**Phone: 952-992-5200**
**Release of Information Fax: 612-813-5980**

**(O*ffice use only*)**
**Staff Initials _____**

**# of pages _____**

**ID Verified: ☐ Yes**
**Comments:**

_____
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_____

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2. Scan or take a photo of your completed form.
3. Log in to your MyChildren's account.
4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management.**

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name _____ Date of Birth _____

**I authorize (release from):**

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

**To release To:** _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

**Purpose of release**: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

**Information needed by (date):** _____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: _____

**Information needed from the following clinics:**
☐Children's Heart Clinic ☐Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐Other:_____

☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

**Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal ☐ MyChildren's**

**☐ Email_____(HIM only)**

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
  I don't want the following records released: _____.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

* R O I *

Children's MINNESOTA

**Our Community Clinics**
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Calhoun, Maple Grove, Plymouth, Rogers

# MIDDLE/HIGH SCHOOL PROGRESS REPORT

Student Name: _____ Date of Birth: _____ Today's Date: _____

Teacher: _____ Class/Subject: _____ Period or Time: _____

Please rate this student based on current school performance to this point in the term.
(Circle appropriate answers for each row)

| | | | | | |
|---|---|---|---|---|---|
| 1. Approximate current Grade | A | B | C | D | F or IC |
| 2. % of assigned work completed | 90-100% | 80-89% | 66-79% | 50-65% | 0-49% |
| 3. Able to pay attention without prompting | Always | Often | Sometimes | Rarely | Never |
| 4. Follows class discussion and teacher instructions | Always | Often | Sometimes | Rarely | Never |
| 5. Learns new material | Very Quickly | Quickly | Average | Slowly | Very Slowly |
| 6. Follows rules of behavior | Always | Often | Sometimes | Rarely | Never |

**Comments:**