

## SCHOOL PROBLEMS EVALUATION MEDICAL HISTORY FORM

Child's name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Date form filled out: \_\_\_\_\_

Your name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Referred by: \_\_\_\_\_

Child's private physician: \_\_\_\_\_

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

<u>Date</u>	<u>Name of Physician, psychologist, agency, or clinic</u>
_____	_____
_____	_____
_____	_____

Please attach a recent picture:



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

When did these problems begin? \_\_\_\_\_

What do you hope to get out of this evaluation? \_\_\_\_\_

## 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 \_\_\_\_\_

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HOME/FAMILY**

Family Member	Name	Years of School/Degree	Occupation
Father			
Mother			
Stepfather			
Stepmother			

Parents are: ☐ married ☐ separated ☐ divorced ☐ never married

Please share any history of significant (if any) marital problems: \_\_\_\_\_

Custody arrangements if applicable: \_\_\_\_\_

Who lives at home with this child? \_\_\_\_\_

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

---



---



---



---



---



---

Please describe any conflict surrounding homework: \_\_\_\_\_

---



---



---

Please describe how you discipline your child: \_\_\_\_\_

---



---



---

**SOCIAL**

How many close friends does your child have? \_\_\_\_\_

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):

---



---

How many hours per day does your child watch TV and play video games? \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SELF-ESTEEM**

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

---



---



---



---

**PAST MEDICAL HISTORY**Was this child adopted? ☐ Yes ☐ No**PREGNANCY**Was this pregnancy planned? ☐ Yes ☐ No

<b>PREGNANCY COMPLICATIONS</b>	<b>Yes</b>	<b>No</b>
Bleeding		
Premature labor		
High blood pressure		
Toxemia		
Infections		
Weight gain less than 15 lbs.		
Diabetes		
Smoking		
Drug use *		
Alcohol use: # of drinks/day _____		
Emotional or family problems *		
Previous stillborns/miscarriages		

Specify any medications/drugs or other details:

---



---



---



---



---

**LABOR AND DELIVERY:**Length of pregnancy: \_\_\_\_\_ Type of delivery: ☐ Vaginal ☐ Cesarean

Mother's age at delivery: \_\_\_\_\_

Complications:

- ☐ fetal distress (heart rate drop)  
☐ meconium (bowel movement) passage before birth  
☐ forceps use  
☐ breech delivery  
☐ other, describe \_\_\_\_\_

**NEWBORN HISTORY:**

Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Complications at birth (check those that apply):

- ☐ None  
☐ Needed oxygen  
☐ Difficulty breathing/respiratory distress  
☐ Treated in an intensive care unit (NICU)
- ☐ Jaundice  
☐ Low blood sugar  
☐ Infection/ pneumonia  
☐ Other: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**GROWTH**

Has your child had any problems with (if yes, please describe):

Weight loss or gain: ☐ No ☐ Yes: \_\_\_\_\_Growth in height or length: ☐ No ☐ Yes: \_\_\_\_\_Head size: ☐ No ☐ Yes: \_\_\_\_\_

Additional details or comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DEVELOPMENT**Did your child's development seem normal compared to other children? ☐ No ☐ Yes

Developmental milestone	Age Achieved
Rolled over	
Sat alone	
Walked alone	
First words (mama-dada)	
Two word sentences	
Toilet trained – days	
Toilet trained – nights	
Dress self	

**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: \_\_\_\_\_

**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.

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

Father's age: \_\_\_\_\_

Mother's age: \_\_\_\_\_

Sister(s) name and ages: \_\_\_\_\_

Brother(s) name and ages: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FAMILY HEART HISTORY:**

If a member of your child's family has had any of these medical problems, please record their relationship to your child.

PROBLEM	NO	YES	RELATIONSHIP
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			

**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			

**CHILD'S MEDICAL HISTORY:**Are immunizations up to date? ☐ No ☐ Yes (Please include a copy of current immunization records)

Describe any serious reactions: \_\_\_\_\_

List any known allergies to medications, foods, pollens or inhalants: \_\_\_\_\_

\_\_\_\_\_

Describe any hospitalizations or surgery (date, reason, problems): \_\_\_\_\_

\_\_\_\_\_

Describe or list any chronic or serious past illnesses (include dates, medications, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**MEDICATIONS:**

Please list currently prescribed or over the counter medications taken and their doses:

_____	_____
_____	_____
_____	_____

**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)			



## PARENT SCHOOL PROGRESS FOLLOW-UP EVALUATION

Parent to Complete in the month of \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Phone Number: \_\_\_\_\_

- Are your child's ADHD symptoms controlled consistently throughout the day? ☐ Yes ☐ No
- If your child is currently taking ADHD medication, how long does it control his/her symptoms? \_\_\_\_\_ Hours.
- Are your child's ADHD symptoms controlled during after-school hours including homework time? ☐ Yes ☐ No
- If not, what ADHD symptoms are not adequately controlled during this time? \_\_\_\_\_
- Do you feel that your child needs more symptom control than what is provided by his/her current ADHD treatment plan? ☐ No ☐ Yes
- Do you feel that your child's current or prior ADHD medication is/was well tolerated? ☐ Yes ☐ No

SYMPTOMS WHILE ON MEDICATIONS	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. Is fearful, anxious, or worried.	0	1	2	3
28. Is afraid to try new things for fear of making mistakes.	0	1	2	3
29. Feels worthless or inferior.	0	1	2	3
30. Blames self for problems, feels guilty.	0	1	2	3
31. Feels lonely, unwanted, or unloved; complains that "no one loves him or her".	0	1	2	3
32. Is sad, unhappy, or depressed.	0	1	2	3
33. Is self-conscious or easily embarrassed.	0	1	2	3



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC	
34. Overall school performance	1	2	3	4	5	
35. Reading	1	2	3	4	5	
36. Writing	1	2	3	4	5	
37. Mathematics	1	2	3	4	5	
38. Relationships with parents.	1	2	3	4	5	
39. Relationships with siblings.	1	2	3	4	5	
40. Relationships with peers.	1	2	3	4	5	
41. Participation in organized activities (e.g. teams)	1	2	3	4	5	
<b>Side Effects:</b> Has your child experienced any of the following side effects or problems in the past week?			<b>NONE</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>
Change of appetite			0	1	2	3
Weight loss			0	1	2	3
Trouble sleeping			0	1	2	3
Dull, tired, listless behavior			0	1	2	3
Chest pain			0	1	2	3
Stomachache			0	1	2	3
Headache			0	1	2	3
Tremors/feeling shaky			0	1	2	3
Repetitive movements, tics, jerking, twitching, eye blinking			0	1	2	3
Picking at skin or fingers, nail biting, lip or cheek chewing			0	1	2	3
Irritability in the late morning, late afternoon, or evening			0	1	2	3
Problem behaviors when medications are wearing off			0	1	2	3
Excessive worrying, anxiety			0	1	2	3
Sees or hears things that aren't there			0	1	2	3
Socially withdrawn – decreased interaction with others			0	1	2	3
Extreme sadness or unusual crying			0	1	2	3
Dizziness			0	1	2	3
Skin rash			0	1	2	3

**COMMENTS:**

**For Office Use Only**

Inattention 1-9: \_\_\_\_\_/9      Hyp-Imp 10-18: \_\_\_\_\_/9      ODD 19-26: \_\_\_\_\_/8      Dep / Anx 27-33 \_\_\_\_\_/7

Strengths:

Weaknesses:

## ADHD FOLLOW-UP SELF-REPORT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Your Phone Number: \_\_\_\_\_

- Are your ADHD symptoms controlled consistently throughout the day? ☐ Yes ☐ No
- If you are currently taking ADHD medication, how long does it control your symptoms? \_\_\_\_\_ Hours.
- Are your ADHD symptoms controlled during after-school/work hours including homework time? ☐ Yes ☐ No
- If not, what ADHD symptoms are not adequately controlled during this time? \_\_\_\_\_
- Do you feel that you need more symptom control than what is provided by your current ADHD treatment plan? ☐ No ☐ Yes
- Do you feel that your current or prior ADHD medication is/was well tolerated? ☐ Yes ☐ No

SYMPTOMS WHILE ON MEDICATIONS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. I do not pay attention to details, make careless mistakes on homework or other work.	0	1	2	3
2. I have difficulty paying attention to what needs to be done.	0	1	2	3
3. I do not 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 agitated and restless.	0	1	2	3
13. I have difficulty 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
19. I argue with others often.	0	1	2	3
20. I lose my temper.	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 deliberately annoy people	0	1	2	3
23. I blame others for my mistakes or misbehavior.	0	1	2	3
24. I am touchy or easily annoyed by others.	0	1	2	3
25. I am angry or resentful.	0	1	2	3
26. I am spiteful and want to get even.	0	1	2	3
27. I am fearful, anxious, or worried.	0	1	2	3
28. I am afraid to try new things for fear of making mistakes.	0	1	2	3
29. I feel worthless or inferior.	0	1	2	3
30. I blame myself for problems, feel guilty.	0	1	2	3
31. I feel lonely, unwanted, or unloved; complain that "no one loves me."	0	1	2	3
32. I am sad, unhappy, or depressed.	0	1	2	3
33. I am self-conscious or easily embarrassed.	0	1	2	3



Continued on Reverse

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
34. Overall school/work performance	1	2	3	4	5
35. Reading	1	2	3	4	5
36. Math	1	2	3	4	5
37. Writing	1	2	3	4	5
38. Relationships with parents.	1	2	3	4	5
39. Relationships with siblings.	1	2	3	4	5
40. Relationships with peers.	1	2	3	4	5
41. Relationship with spouse/significant other.	1	2	3	4	5

Side Effects: Have you experienced any of the following side effects or problems in the past week?	NONE	MILD	MODERATE	SEVERE
Change of appetite	0	1	2	3
Weight loss	0	1	2	3
Trouble sleeping	0	1	2	3
Dull, tired, listless behavior	0	1	2	3
Chest pain	0	1	2	3
Stomachache	0	1	2	3
Headache	0	1	2	3
Tremors/feeling shaky	0	1	2	3
Repetitive movements, tics, jerking, twitching, eye blinking	0	1	2	3
Picking at skin or fingers, nail biting, lip or cheek chewing	0	1	2	3
Irritability in the late morning, late afternoon, or evening	0	1	2	3
Problem behaviors when medications are wearing off	0	1	2	3
Excessive worrying, anxiety	0	1	2	3
Sees or hears things that aren't there	0	1	2	3
Socially withdrawn – decreased interaction with others	0	1	2	3
Extreme sadness or unusual crying	0	1	2	3
Dizziness	0	1	2	3
Skin rash	0	1	2	3

**COMMENTS:**

**For Office Use Only**

Inattention 1-9: \_\_\_\_\_/9      Hyp-Imp 10-18: \_\_\_\_\_/9      ODD 19-26: \_\_\_\_\_/8      Dep / Anx 27-33 \_\_\_\_\_/7

Strengths:

Weaknesses:

Provider Initials: \_\_\_\_\_

## 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 <b><i>past year</i></b> have you felt depressed or sad most days, even if you felt okay sometimes? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you <b><i>ever</i></b> , in your <b><i>whole life</i></b> , tried to kill yourself or made a suicide attempt? <input type="checkbox"/> Yes <input type="checkbox"/> No

FOR OFFICE USE ONLY Score \_\_\_\_\_

Q 12 and Q 13 = Y or TS =  $\geq 11$

Date completed: \_\_\_\_\_

PLACE PATIENT LABEL HERE



## GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

Not  
at all

Several  
days

More than  
half the  
days

Nearly  
every day

(Use "✓" to indicate your answer)

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

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.





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**

(Office use only)

Staff Initials \_\_\_\_\_

# of pages \_\_\_\_\_

ID Verified: ☐ Yes  
Comments: \_\_\_\_\_

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

☐ Operative Report

☐ Consultation

☐ Immunizations

☐ Emergency Department Visit

☐ Laboratory Report

☐ Testing Records

☐ Mental Health Record

☐ History and Physical

☐ X-Ray Report

☐ X-Ray Image(s)

☐ Clinic Visit

☐ Progress Notes

☐ Billing Information

☐ 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: \_\_\_\_\_









# 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:**

