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: _____ 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:

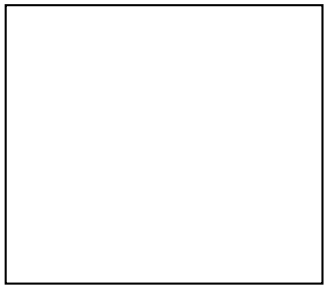
Date Name of Physician, psychologist, agency, or clinic

_____

_____

_____

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

PREGNANCY COMPLICATIONS	Yes	No
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.

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					
Mental retardation					
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					
Smoking or chewing tobacco					
MEDICAL/NEUROLOGICAL					
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)			

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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

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

Continued on Reverse

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

Side Effects: Has your child 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:_____

Children's MINNESOTA

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

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:_____

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

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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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)

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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_____
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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

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: