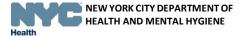
REQUEST FOR HEALTH SERVICES/SECTION 504 ACCOMMODATIONS PARENT FORM 2023-2024 DOB _____Student ID# _____ Name of Student School ATS/DBN Grade/Class ____ School Name Name of Requesting Parent/Guardian Relationship to Student Name of 504 Coordinator Relationship to Student Does the student have a current IEP? Yes No 504 Coordinator Tel. # Part 1: Parent/Guardian must complete and submit to the school's 504 Coordinator or IEP team Describe the concern below and how it affects the student's performance at school: Request accommodations based on the concerns listed above. Please contact your school's 504 Coordinator or IEP team with any questions. Request for Accommodation(s) **New Request** Renewal Request Guardian Checks all requested: For school use only For school use only **Testing Accommodations** ☐ Test schedule/administration time (e.g., extended time) ☐ Test setting/location ☐ Method of presentation/Directions/Assistive Technology ☐ Method of test response/content support ☐ Other (please specify) Classroom / Curriculum Accommodations ☐ Class schedule/use of time ☐ Class activities setting ☐ Method of presentation/Directions/Assistive Technology ☐ Method of class activities response/Content Support П ☐ Other (please specify) **Academic Supports and Other Services** Paraprofessional □1:1 □ Other **Nursing Services** □ 1:1 ☐ School Nurse П ☐ Transportation (if for a temporary medical condition or short- or long-term limited mobility, submit the Medical Exception Request forms to the Office of Pupil Transportation) ☐ Safety Net (high school only) ☐ Other (please specify) When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse; the Medication Administration Form must be submitted to the school nurse. Requests for 1:1 nursing, paraprofessional support, and transportation will be reviewed on a case-by-case basis by an Office of School Health (OSH) Practitioner to confirm that services are medically needed. Decisions about whether a student requires a particular accommodation are made by the 504 Team or IEP team, which includes the parent. Additional forms must be completed; please check with your 504 Coordinator or IEP team. The New York City Department of Education (DOE) will review Assistive Technology requests and may facilitate an evaluation to determine the student's needs. Part 2: PARENT CONSENT - Parent/Guardian must complete before submitting to your school's 504 Coordinator or IEP team Your child may qualify for accommodations under Section 504 of The Rehabilitation Act of 1973. Your school's 504 team and/or IEP team will meet to review your child's records, classwork, classroom observations, testing, and health care practitioner's statement. If your child qualifies for services based on that review, the team will create a 504 Plan and/or IEP with your help and consent. 504 Plans must be reviewed before the end of each school year or more often if necessary. By signing this form: 1) I am giving consent to the 504 team and/or IEP team to review my child's records and decide if my child gualifies for accommodations. 2) I confirm that I have provided full and complete information to the best of my ability. 3) I understand that the OSH and the DOE are relying on the accuracy of the information on the form for their review and decisions. 4) I understand that the OSH and the DOE may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

☐ Completed HIPAA form attached (REQUIRED FOR REVIEW. PARENTS MUST COMPLETE THE BACK OF THIS FORM).	
Name of Parent/Guardian	
Signature of Parent/Guardian	_Date



Patient Name

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA **Date of Birth**

Patient Identification Number

D. 11 . A 1 1		
Patient Address		
accordance with New York State Law and Privacy Rule of the Health In 1. This authorization may include disclosure of information relating psychotherapy notes, and CONFIDENTIAL HIV/AIDS* RELATED INFO event the health information described below includes any of these authorize release of such information to the New York City Depa Department of Education ("DOE"), which jointly operate the Office of 2. If I am authorizing the release of HIV/AIDS-related, alcohol or druftom redisclosing such information without my authorization unless right to request a list of the people who may receive or use my HIV/because of the release or disclosure of HIV/AIDS-related information, or the New York City Commission of Human Rights at (212) 306-7450. 3. I have the right to revoke this authorization at any time by writin understand that I may revoke this authorization except to the extent 4. I understand that signing this authorization is voluntary. My treatment of the conditioned upon my authorization of this disclosure. 5. Information disclosed under this authorization may be redisclosed may no longer be protected by federal or state law.	Interest in the second	
 7. Specific information to be released and discussed: All health information (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to my health care providers by other health care providers. If this box is checked, release and discuss only health information specified here: 		
(Use this box if you do not want the entire record released or disclosed. Use box 9 below to set how long you want this form to last) Include: (Indicate by Initialing) Alcohol/Drug Treatment Information. Specify records to be released and releasing organization: Mental Health Information HIV/AIDS-Related Information		
8. REASON FOR RELEASE OF INFORMATION: THIS INFORMATION IS RELEASED AT REQUEST OF THE PATIENT OR REPRESENTATIVE, UNLESS OTHERWISE SPECIFIED HERE:	9. THIS AUTHORIZATION EXPIRES ON THE DATE THAT PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS OTHERWISE SPECIFIED HERE**:	
10. IF NOT THE PATIENT, NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)	11. THE PERSON SIGNING THIS FORM IS AUTHORIZED BY LAW TO SIGN ON BEHALF OF THE PATIENT AS THE PARENT OR LEGAL GUARDIAN OF THE PATIENT, OR AS SPECIFIED HERE:	
All items on this form have been completed, my questions about this for	m have been answered and I have been provided a copy of the form.	

OSH-13 HIPAA Rev.04.2021

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

DATE

^{*}Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

^{**}If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law.