REQUEST FOR HEALTH SERVICES/SECTION 504 ACCOMMODATIONS PARENT FORM 2023-2024

Name of Student _____ DOB _____ Student ID# _____

School Name _____ School ATS/DBN _____ Grade/Class _____

Name of Requesting Parent/Guardian _____ Relationship to Student _____

Date Submitted to the 504 Coordinator _____ Name of 504 Coordinator _____

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) *Guardian Checks all requested:*	**New Request** *For school use only*	**Renewal Request** *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	☐	☐
☐ Other (please specify)	☐	☐
	☐	☐
Academic Supports and Other Services		
Paraprofessional		
☐ 1:1	☐	☐
☐ Other	☐	☐
Nursing Services	☐	☐
☐ 1:1	☐	☐
☐ School Nurse	☐	☐
☐ 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 qualifies 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 _____ Daytime Phone Number _____

Signature of Parent/Guardian _____ Date _____

FOR PRINT USE ONLY

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV/AIDS* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7, I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.
2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care providers I have authorized to release my information. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization may be redisclosed by DOHMH or DOE (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION.**

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 form have been answered and I have been provided a copy of the form.

_____ _____

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.**