SALEM SCHOOL SYSTEM
Salem, Connecticut

STUDENTS

RECOMMENDATIONS FOR USE OF PSYCHOTROPIC DRUGS: PROCEDURES

Any communication between school health or mental health professionals and other school personnel regarding the possibility of a recommendation for a medical evaluation, must be guided by Connecticut State Statute that prohibits school personnel from recommending the use of psychotropic drugs for any child.

The method in which school health or mental health personnel communicate a recommendation to a parent or guardian that a child be evaluated by an appropriate medical practitioner is most often through a Planning and Placement Team decision. In those rare instances where emergency medical intervention is necessary, school health or mental health personnel, in consultation with an administrator, may make this recommendation.

An Authorization for Exchange of Health and Education Information form must be completed and signed by a parent or guardian prior to any communication between school personnel and medical practitioners who are not school employees.

Procedures developed: November 15, 2004
1st Reading: December 13, 2004
Procedures Adopted: January 4, 2005

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Authorization for Exchange of Health and Education Information

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ *(insert health care provider name & title)*

and _____ (*insert name & title of school official)* to exchange health and education information/records for the purpose listed below.

Salem School, 200 Hartford Road, Salem, CT 06420 Phone: 860-859-3988/860-859-0267 Fax 860-859-2130
(insert address & telephone number of school/school district)

_____ *(insert address & telephone number of health care provider)*

Description:
The health information to be disclosed consist of:

The education information to be disclosed consists of:

Purpose: This information will be used for the following purpose(s):
1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Other: _____
_____

Authorization

This authorization is valid for one calendar year. It will expire on _____(*insert date).* I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, one received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____
Parent Signature Date

_____ _____
Student Signature* Date

**If a minor is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Connecticut, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.*

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Developed collaboratively with: CT State Department of Education & CT Chapter, American Academy of Pediatrics