National Jewish Health®

Morgridge Academy

Morgridge Academy
Student Information Sheet
2013-2014
303-398-1103

Name of Child: _____
First Middle Last

Child's Social Security #: _____-_____-_____ DOB: _____/_____/_____

Is this student Hispanic/Latino?
☐ No, not Hispanic/Latino
☐ Yes, Hispanic/Latino

What is the student's race? (choose all that apply)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Name of Parent/Guardian that child resides: _____
First Last

Parent/Guardian Name: _____
First Last

Address: _____
Street City State Zip

Email Address: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Occupation: _____

Parent/Guardian Name: _____
First Last

Address: _____
Street City State Zip

Email Address: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Occupation: _____

Parents are: Married_____ Divorced_____ Single _____ Remarried_____

If divorced, unmarried, or remarried, who has custody? _____
*****Any legal/custody papers need to be on file in the school office***

INSURANCE (**Must be Completed**)

Name of Insurance Company: _____

Subscriber's Name: _____ Relationship: _____

Subscriber ID/Policy #: _____ Group #: _____

Telephone # for Insurance Company: _____

Please complete other side →

National Jewish Health®
Morgridge Academy

Morgridge Academy
Student Information Sheet 2
2013-2014
303-398-1103

Hospital Preference: ☐ National Jewish ☐ Denver Health ☐ Children's Hospital ☐Rose Medical
☐ Other:_____

PRIMARY CARE PHYSICIAN (Must be Completed)

Doctor's Name: _____ Office Phone: (_____)_____-_____

Office Address: _____
Street City State Zip

DENTIST
Doctor's Name: _____ Office Phone: (_____)_____-_____

Office Address: _____
Street City State Zip

EMERGENCY CONTACTS WHO ARE AUTHORIZED TO PICK CHILD UP FROM SCHOOL:
(Must be completed-Other than Parent/Guardian on front)

Name: _____ Relationship to Child: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Name: _____ Relationship to Child: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Name: _____ Relationship to Child: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

TRANSPORTATION WILL BE PROVIDED BY:

☐Parent
☐Daycare Name: _____
☐RTD
☐Other : _____

SCHOOL DISTRICT OF RESIDENCE: _____

EVALUATION PERMISSION:
I understand that in order to increase school personnel's understanding of my child's educational needs, one or more of the following assessments/screenings may be necessary:

Educational, Hearing Screening, Speech/Language Screening, Occupational Therapy Screening, Physical Therapy Screenings.

I grant permission of Morgridge Academy and/or National Jewish Health personnel to perform the above assessments as deemed appropriate. Furthermore, I release school personnel from all liability and all claims pertaining to the use of this information by appropriate National Jewish Heath employees.

Parent/Guardian Signature:_____ Date:_____

National Jewish Health®
Morgridge Academy

Morgridge Academy
Parent/Guardian Signature List
2013-2014
303-398-1103

Student's Name: _____

Field Trip Participation:

Each year classes participate in several field trips and other educational activities that require the students to leave the building for several hours. When a field trip is planned, a letter will be sent home explaining where the class is going and the purpose, date, time of the trip, and cost, if any, to the family.

I hereby give permission for my child to participate in the field trips taken during the school year.

_____ _____
Parent/Guardian Signature Date

Photo/Video Release:

I hereby give permission for the above name to be photographed and/or videotaped for use by the mass media and National Jewish Health/Morgridge Academy.

_____ _____
Parent/Guardian Signature Date

National Jewish Health
Morgridge Academy

Morgridge Academy
Human Sexuality Release Letter
2013-2014
303-398-1103

Dear Parents,

Due to a bill that has been passed, schools are now required to include a program that teaches our students about human sexuality. We will be incorporating this program into our curriculum for students that are in kindergarten through 8th grade. Teachers, nurses, and Wally will be talking to our children about this topic throughout the school year. Each topic will be covered at an age appropriate level.

Some of the topics will include hygiene, good/bad touches, puberty, relationships, sexually transmitted diseases, staying healthy, hand washing, dental hygiene, diet and nutrition, and other topics that involve the body and healthy living. We ask that all students participate in this program because it is an essential part of their education and also important for them to hear this information in school and at home.

We would like to involve the family as much as we can in this program and will be sending home information for you to read. This information will inform you of what is being discussed as well as ways you can talk to your child about what they are learning at school.

Please sign the line below to show your consent for your child to take part in this program with their class.

Thank you,
Morgridge Academy Staff

Check one and sign:
☐ **I agree** to have my child participate in the Human Sexuality program that is required by the State of Colorado under bill HB 1292.

☐ **I would NOT** like my child to participate in the Human Sexuality program that is required by the State of Colorado under bill HB 1292.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

National Jewish Health
Morgridge Academy

Morgridge Academy
Uniform Dress Code Policy
2013-2014
303-398-1103

Why do we wear uniforms?

We wear uniforms at Morgridge Academy to help promote school unity. Uniforms help students focus on learning instead of how they look. As visitors come to our school we show them the pride we have in ourselves by following the uniform code and dressing appropriately.

What is the uniform for students?

Shirts Must be collared shirts (polo shirts, button down collared shirts, and turtlenecks are ok) Shirt colors must be white, baby blue, navy blue, or maroon. No T-Shirts are to be worn as a uniform shirt (unless it is a Morgridge T-Shirt) Shirts must be worn appropriately and tucked in at all times. Shoulders and stomachs must be covered at all times.	Pants, Shorts or Skirts Must be navy blue, tan, or khaki. Pants may not be sagging. Skirts or shorts must be knee-length, cannot be skin tight. **Jeans are not acceptable uniform pants.**
Shoes Tennis shoes or sneakers are preferred, as students attend PE and recess every day. No Flip-Flops.	Head Gear Can only be worn outside. This includes bandanas.
Outer gear Sweatshirts or sweaters worn inside the building must be the uniform color or the child will be asked to remove the covering. The uniform colors are maroon, navy blue, baby blue, and white. Hoods are not to be worn in the building	

Are there any days that students are not required to wear uniforms?

The principal is the only person that can designate a day without uniforms. At this time, Fridays are designated to be a non-uniform day.

What happens when a student does not wear their uniform?

Students are expected to wear their uniform at all times while at school. If a student does not wear a uniform, the parent will be notified to provide the uniform. If the parent cannot be reached, the student will wear a uniform borrowed from the school or will be asked to go home. Continued non-compliance will be addressed and consequences decided by the principal.

Uniform Policy Signed Agreement

I understand the requirements for my child to wear a uniform to **and from** Morgridge Academy. By signing this, I am in agreement with, and will provide my child with the appropriate uniform. I understand if my child is non-compliant with the uniform that I will be called to bring the appropriate uniform or to meet with the Morgridge Staff.

Parent/Guardian Signature:_____ Date:_____

I understand that as a student at Morgridge Academy I am required to wear a uniform **to and from school each day**. I have been told what the uniform requirements are and I agree to be compliant with the uniform policy. I understand that every Friday I am allowed to wear the clothes of my choice.

Student Signature:_____ Date:_____

National Jewish Health®
Morgridge Academy

Morgridge Academy
Attendance/Tardy Policy
2013-2014
303-398-1103

Your child should only be kept home if the following conditions are present:

1. Temperature over 101
2. Persistent vomiting

We are a school for chronically ill children and are staffed to care for those that have missed a large number of school days in their previous placement due to health. If your child is experiencing any health related symptoms, send them to school and they will be monitored by the nurses. Due to the nature of our school, if your child needs to miss school due to illness, they should be seen by a doctor. If your child misses 3 or more days of school in a row, a doctor's note is required for your child to return to school. The Colorado Compulsory School Attendance Act requires students to be in attending school for 95% of the school year. Excessive absences may demand legal action as required by this law. The following steps will be taken based on the number of unexcused absences a child may have.

If a child misses or is tardy to school:

4 unexcused absences- The parent will receive a phone call from staff to help families solve problems preventing school attendance or tardiness.

8 unexcused absences- A letter will be sent home reminding parents of the state laws and school guidelines for attendance and tardiness.

10 unexcused absences- The parent will be required to meet with Morgridge Academy staff to discuss issues that may be contributing to the child missing school or being tardy.

12 + unexcused absences- Morgridge Academy is required to take legal action in the case of excessive absences as stated by the Colorado Compulsory School Attendance Act. The steps taken could include a call to social services with concerns of educational neglect, possible truancy court, or other consequences determined by Colorado State Law.

An excused absence includes: Illness (meeting the requirements stated above) official school-sponsored activities, court appearances, medical appointments, serious illness in the immediate family, death in the immediate family, and other extenuating circumstances not covered that the school determines are excused. Absences for reason other than the issues listed above will be deemed unexcused.

It is very important for children to be at school every day. The structure and education they receive here at Morgridge Academy will help make them be successful in the future. Routine and consistency in a child's education are crucial elements in helping them develop and excel. It is very difficult for children coming in late because it is a disruption both to the classroom and the student. Children have a difficult time when routines are changed or altered.

Attendance/Tardy Policy Signed Agreement

I want my child to be a successful student at Morgridge Academy and in life. I will continue to support my child's education and well being by bringing them to school on time and prepared every day possible.

- **I am aware that school begins at 7:45 am and ends at 3:20 pm. I understand that excessive absences or tardiness could jeopardize my child's placement at Morgridge Academy.**
- **I am aware that my student will receive a tardy slip after 7:50am. Excessive tardiness will result in the same consequences as listed above.**
- **All calls concerning your child's attendance must be called in to the School Nurse Clinic by 9am at 303-398-1488.**

I am aware of and agree with the Attendance/Tardy policy of Morgridge Academy.

Parent/Guardian Signature:_____ Date:_____

National Jewish Health™
Science Transforming Life™

CONSENT TO TREATMENT

Attach patient label here.

CONSENT FOR HOSPITAL OR OUTPATIENT CARE: I hereby voluntarily consent to the rendering of healthcare services by National Jewish employees, medical staff or others holding clinical privileges, including, routine hospital services, diagnostic procedures, intravenous therapy, medical treatment, and other hospital care and services. These services may be rendered under the direction and supervision of the medical staff of the National Jewish Health. If the patient is initially seen as an outpatient and the attending physician determines during the course of such outpatient care that the patient's condition would be best managed on an inpatient basis, I hereby consent to such inpatient admission and agree that the terms of this agreement are in effect for inpatient admission. If the patient is initially admitted as an inpatient and it is determined that the patient's care can be managed in an outpatient setting, I hereby consent to such services. I understand that I have the right to discuss proposed procedures or treatments with the physician and to consent to, or refuse such procedures or treatments. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the results of examination or treatment at National Jewish.

EMERGENCY TREATMENT: I hereby authorize any medical or surgical treatment deemed necessary by the medical staff of National Jewish, should that care become necessary in the event of an emergency when any delay in rendering care could result in irreparable harm to or death to the patient. I understand that because National Jewish is a specialty hospital and that it does not routinely provide surgical and general medical care, the patient may be transferred to another local hospital deemed by the medical staff of National Jewish to have the appropriate facilities for treatment. I hereby give consent to any such transfer.

WAIVER OF RESPONSIBILITY FOR DISCHARGE AGAINST OR WITHOUT MEDICAL ADVICE: If I choose to leave the healthcare facility against or without the advice of my physician, I hereby release the physician, National Jewish Health, its agents and employees from all liability for any ill effects which may result.

RELEASE OF INFORMATION: I hereby authorize National Jewish and its physicians and employees to release information from the patient's medical records for treatment, payment and healthcare operations purposes as described in the National Jewish Notice of Privacy Practices, including to any healthcare provider involved in any way in the care of the patient and to any person or entity which may be liable for all or part of the charges for services, goods or facilities provided to the patient. I also authorize the release of information needed for discharge planning, utilization reviews, transfer, follow-up and other purposes as the physicians and others providing care at National Jewish deem appropriate. I understand that following the release of this information, the health care facility cannot control its confidentiality. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

PERSONS BOUND BY THIS AGREEMENT: If appropriate, the term "Patient" as used herein shall mean the Patient's legal representative, including, but not limited to, the Patient's parent, conservator, or guardian.

PRE-AUTHORIZATION: I understand that it is my sole responsibility to obtain all insurance referrals and to provide all information necessary to obtain any pre-authorizations required by my insurance company. I further understand that it is my sole responsibility to comply with all requirements of any insurance or medical/hospital coverage plan under which I am relying for coverage of the National Jewish charges.

MEDICARE AND MEDICAID: I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct. I authorize release of information needed to act on this request. I request that payment of hospital and physician Medicare and Medicaid benefits, if applicable, be made on my behalf.

Patient Initial_____(Has read document)

Attach patient label here.

THIRD PARTY ASSIGNMENT/FINANCIAL AGREEMENT: I, the undersigned, hereby represent and agree as follows:

1. I am responsible for full payment of all National Jewish bills, and I must pay amounts within a time period National Jewish deems reasonable. I understand that National Jewish may bill insurance companies or other third-party payers on my behalf, but that there is no obligation to do so. I hereby authorize payment to be made directly to National Jewish, from any insurance or health care benefits, otherwise payable to me for health care services, goods and facilities provided by National Jewish. I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer and that I am financially responsible for all charges not paid for any reason, including but not limited to charges that are non-covered , not billed, not collected, or otherwise not paid by insurance companies or other third-party payers. No extensions, forbearances or delays in enforcing any rights of collection of charges shall in any manner release or affect my responsibility therefore. I understand that unpaid balances, not otherwise paid by insurance, over ninety days old will include a delinquent or interest charge at the rate of one-and-one-half percent (1.5%) per month or the maximum rate allowed by law.
2. I agree to pay all costs and expenses, including, but not limited to, reasonable attorney's fees and costs incurred by National Jewish in collecting any amounts not otherwise paid by insurance.
3. I hereby assign to National Jewish any and all claims and causes of action of any kind whatsoever against an insurance company or other third party payer or against any other person or entity for payment or reimbursement for services, goods or facilities provided by National Jewish. I understand that this assignment is given to permit National Jewish to pursue these claims on my behalf as a courtesy to me and that National Jewish is not required to exercise these rights and may do so in its sole discretion without any liability for its decision. I also agree that this assignment does not in any way affect my obligation and agreement to pay National Jewish's charges. I understand that this assignment takes effect upon notice by National Jewish that it intends to exercise these rights.

WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES: I understand that I should not keep any money or valuable property with me while at National Jewish. I understand that National Jewish does not assume responsibility for the loss or damage to the patient's personal property.

MANDATORY DISCLOSURE STATEMENT: While I or my minor child is a Patient at National Jewish, I may be seen by a licensed or unlicensed psychologist, counselor, or medical or clinical social worker who may assist me with counseling or discharge planning services. I have been informed that Colorado Law requires that institutions present the following rights: Any Patient who is seen by a licensed or unlicensed psychologist, counselor, or social worker in the State of Colorado is entitled to receive information about that person's degrees and credentials; the methods, techniques and duration of therapy, if known; and fee structure. A Patient may seek a second opinion or terminate therapy at any time. Sexual intimacy within a professional relationship is never appropriate and should be reported to the State Grievance Board. Information provided by a Patient in counseling is generally confidential, and exceptions that arise during therapy will be identified and discussed.

USE OF INFORMATION IN DIAGNOSIS AND TREATMENT: The Patient hereby authorizes National Jewish to photograph; preserve; use for scientific or teaching purposes; and/or to otherwise dispose of the tissues, parts, or body samples resulting from any procedure the Patient undergoes at National Jewish.

ADVANCE DIRECTIVES: Please indicate below if the patient has an advance directive in place. If so, please provide a copy of the advance directive to National Jewish for inclusion in the medical record.

☐ **Yes I have an advance directive in place**

☐ **No I do not have an advance directive in place**

ACCEPTANCE: The undersigned certifies that he/she has made this agreement and consent, understands its contents, is the Patient or person duly authorized by the Patient or representative to execute this agreement and to consent to and accept its terms, and has received a copy thereof.

Patient Signature	Parent/Guardian (if Patient is minor/mentally impaired)	Relationship to Patient
Signature of Insured	Witness Signature	Date Time

National Jewish Health™
Science Transforming Life™

CONSENT TO TREATMENT

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2. I agree to pay all costs and expenses, including, but not limited to, reasonable attorney's fees and costs incurred by National Jewish in collecting any amounts not otherwise paid by insurance.
3. I hereby assign to National Jewish any and all claims and causes of action of any kind whatsoever against an insurance company or other third party payer or against any other person or entity for payment or reimbursement for services, goods or facilities provided by National Jewish. I understand that this assignment is given to permit National Jewish to pursue these claims on my behalf as a courtesy to me and that National Jewish is not required to exercise these rights and may do so in its sole discretion without any liability for its decision. I also agree that this assignment does not in any way affect my obligation and agreement to pay National Jewish's charges. I understand that this assignment takes effect upon notice by National Jewish that it intends to exercise these rights.

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Patient Signature	Parent/Guardian (if Patient is minor/mentally impaired)	Relationship to Patient
Signature of Insured	Witness Signature	Date Time

National Jewish Health®
Morgridge Academy

Morgridge Academy Authorization to Use and Disclose Protected Health Information 2013-2014

303-398-1103

Child's Name: _____ DOB: _____

I, _____ , hereby authorize the healthcare providers below to release Records and/or speak with the staff at Morgridge Academy with regard to my child's medical care. Student records will be used to determine student eligibility for enrollment, class placement, academic, medical, and social/emotional goals, and program planning. The National Jewish/Morgridge staff that will have access to this information may include teachers, nurses, principal, therapists, clinicians, and physicians.

Regarding: ☐ Primary Care Physician (PCP) ☐ Medical Summary, PFT, Skin Testing ☐ Other: _____	Regarding: ☐ Psychiatrist ☐ Therapist ☐ Psychologist ☐ Counselor ☐ Social Worker ☐ Other: _____
Physician Name	Physician Name
Address, City, Zip Code	Address, City, Zip Code
Telephone Number Date Initials	Telephone Number Date Initials
Regarding: ☐ Specialist ☐ Medical Summary, PFT, Skin Testing ☐ Other: _____	Regarding: ☐ Specialist ☐ Medical Summary, PFT, Skin Testing ☐ Other: _____
Physician Name	Physician Name
Address, City, Zip Code	Address, City, Zip Code
Telephone Number Date Initials	Telephone Number Date Initials

_____ _____ _____
Parent/Guardian Signature Witness Signature Date

National Jewish Health may not condition treatment, placement, or eligibility for benefits on whether you sign this authorization; however, if you do not authorize the release of this information, you will be denied enrollment in the school. This authorization may be cancelled at any time by means of a written request. If you do cancel this authorization, Morgridge Academy staff will still have access to the protected health information disclosed before the date of the cancellation. After your protected health information has been disclosed, other individuals or entities may re-disclose it. This authorization will not exceed a four-year period of time.

National Jewish Health®
Morgridge Academy

Morgridge Academy
Parent Medical Questionnaire
2013-2014
303-398-1103

Name of Child: _____ DOB: _____/_____/_____

Parent/Guardian Name: _____ Phone #: (_____)_____-_____

Primary Care Physician Name: _____ Office Phone: (____)_____-_____

Specialist Name: _____ Office Phone: (____)___ __-_____

Number of Hospital admissions in past year: _____

Number of Emergency Room visits in past year: _____

Number of Urgent visits to physician in past year: _____

Number of Steroid bursts in past year: _____

Does your child wear glasses? ☐ yes ☐ no

If yes, for what reason? ☐ Reading ☐ Blackboard/Distance ☐ Other: _____

Date of last eye exam: _____

I hereby give permission for the school nurses to give prescribed medications to my child.

I understand that my student will use a spacer device with their metered dose inhaler.

I understand that it is my responsibility to provide the school clinic with the medications the physician has prescribed for this child in a timely manner in the original container.

I understand that my child can only be given Tylenol or Mylanta once a day on an as needed basis without a physician order.

Morgridge Academy staff has my permission to contact my child's physician for medical/medication clarification.

Parent/Guardian Signature:_____ Date:_____

Patients have an important role as members of their healthcare team. As members of their healthcare team, they have rights and responsibilities. Patients rights include:

Professional Care:

- The right to care that is considerate and respectful.
- The right to care that is impartial regardless of gender, race, color, sexual orientation, ancestry, language, religion, disability, socioeconomic status, gender identity or expression, or age.
- The right to access National Jewish rules that affect patients and patient treatment.

Participate in Care Decisions:

- The right to participate in decisions about their care. A patient's family may also participate in care decisions, when appropriate and authorized by the patient.
- The right to receive information that is accurate and easy to understand. This includes information about the patient's diagnosis, the care that is suggested, the risks involved in the treatment or procedure, outcomes of care (including unanticipated outcomes), and the cost of care. With this information, patients can make informed decisions about their care.
- The right to give informed consent before any procedure is performed. If a patient speaks another language, has a physical or mental disability, or just does not understand something, support will be provided so the patient can make informed healthcare decisions.

Treatment:

- The right to refuse treatment at any time, to the extent permitted by law. Should a patient refuse care, the patient's healthcare team will inform the patient of the possible medical consequences of his/her decision.
- The right to refuse participation in a research study without compromising access to other healthcare services.
- The right to appropriate assessment and treatment of pain.
- The right to prepare an advance directive. The patient can appoint another person to make healthcare decisions on his/her behalf to the extent permitted by law. National Jewish personnel will comply with the directive. The patient may revoke or revise the advance directive at any time.
- The right to receive treatment, care and services within National Jewish's mission, capabilities and in compliance with related laws and regulations.
- The right to be informed about unanticipated outcomes of care, treatment and services related to Sentinel Events as defined by The Joint Commission when not already aware of the occurrence.

Confidentiality of Care:

- The right to privacy.
- The right to expect that patient medical records will be kept confidential. Access to information about a patient will be limited to those involved in the patient's care. A release of a patient's medical records without the patient's authorization will only be done in cases of medical emergencies, in response to court-ordered subpoenas, or for regulatory requirements. A patient may provide written consent for release of records to persons or organizations.

Access to Medical Records:

- The right to access a patient's own medical record, except when restricted by law.
- The right to have any information in the record explained.

Caregivers:

- The right to know the names and roles of people directly involved in the patient's care. People will wear official nametags or be introduced.
- The right to know of any business relations National Jewish has that may influence a patient's care.

Continuity of Care:

- The right to continuity of care. National Jewish will help with this. This includes help locating services or facilities when medically indicated. A patient's doctor may suggest that a patient receive care at another facility. If so, the patient's doctor will advise the patient of the reasons for the transfer, the risks involved, and possible options.

Patient Billing:

- The right to have the patient's bill explained to him/her. This will be provided upon request, regardless of the source of payment. A patient may ask about financial aid to assist him/her in payment of the bills. Patients can expect help from National Jewish staff in securing such aid.

Other Rights:

- The right to have access to visitors, telephone calls, mail, and an interpreter, if needed.
- The right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation.
- The right to pastoral care and other spiritual services. Patients may express their spiritual beliefs and cultural practices provided that those practices do not harm others or interfere with their planned course of medical therapy.

Along with patient rights come responsibilities. Patient responsibilities include:

Providing Accurate and Complete Information:

- Patients are responsible for providing complete and accurate information about their health to the best of their knowledge. Patients should be honest and direct about aspects of life that relate to the their illnesses and experiences as patients. The National Jewish healthcare team needs to know patient opinions and concerns to provide patients with quality care.
- Patients are responsible for notifying National Jewish in advance, when possible, if they need interpreters or have other special needs.

Learning About Diagnosis, Testing, and Treatment Plan:

- (Patients are responsible for asking questions. Patients may want to write down their questions before their visits to help them remember.
- Patients are responsible for participating in individual and group patient education sessions. Patients should read the information the healthcare team provides. This will help them become familiar with their treatment plans.
- Patients are responsible for learning about the medicines taken and the equipment used.
- Patients are responsible for Communicating with the healthcare team.
- Patients are responsible for reporting any changes in health to their doctor or nurse.
- Patients are responsible for following the treatment plan and for their actions if they refuse treatment.
- Patients are responsible for being considerate of other patients and National Jewish personnel.
- Patients are responsible for keeping appointments and notifying National Jewish if they are unable to do so.

Following the Rules and Regulations Affecting Patient Care:

- Patients are responsible for not using perfumes or other strong-smelling personal products, such as colognes, lotions, etc. National Jewish requests the same thing of family members and visitors. Strong odors may cause some patients to have trouble breathing.
- National Jewish is a nonsmoking facility. Patients and their visitors are required to refrain from smoking while at National Jewish facilities.
- Patients are responsible for being respectful of the property of other persons and the property of National Jewish.
- Patients may not bring weapons of any kind onto National Jewish property.
- (R) Patients are responsible for meeting their financial responsibilities as outlined in the Payment Agreement signed during the admissions process.
- Patients are responsible for meeting with the Patient Financial Services staff before their appointments if financial assistance in paying the bill is needed.

If a Patient Has Concerns About Ethical Issues Related to Treatment:

- Patients have a right to voice their concerns. Patients may contact the National Jewish Ethics Committee by calling the Patient Representative. Patients can also dial “0” for the operator or ask any member of the healthcare team for assistance.

If a Patient Has a Complaint:

- Patients have the right to file a complaint. To do this, the patient may call the Patient Representative at 303-398-1076. The Patient Representative will look into the complaint and work to resolve the issue.
- Patients may request that a complaint be elevated to a “grievance” status if not satisfied with the Patient Representative process. The complaint will be forwarded to the EVP of Clinical Affairs for further review.
- Patients may contact the Colorado Department of Public Health and Environment if they feel they cannot resolve the issue through National Jewish. The address is 4300 Cherry Creek Circle Drive South, Denver, Colorado, 80222. The telephone number is 303/692-2800.
- Patients may contact our Quality Improvement Organization(QIO) if they have are concerns about the quality of care or premature discharge from National Jewish Health at 1-800-727-7086.
- Patients may also contact National Jewish’s hospital accrediting organization, The Joint Commission, if they are concerned about patient care or safety that National Jewish has not addressed. Contact may be made by calling 1-800-994-6610 or e-mailing complaint@jointcommission.org

National Jewish Health®
Morgridge Academy

Morgridge Academy
Student Medical Evaluation
2013-2014
303-398-1103

Name of Child: _____ DOB: _____/_____/_____

1. DIAGNOSIS:

Asthma: _____ ☐ Mild ☐ Moderate ☐ Severe ☐ N/A

Other Diagnosis _____

2. History of Exercise induced Asthma: ☐ Mild ☐ Moderate ☐ Severe ☐ N/A
3. Physical Findings: _____

_____

4. Medications: To be given at School

PRN: Albuterol MDI 2 puffs or Albuterol Solutions 0.5cc + NS

Or _____ ☐ Yes ☐ No

Pretreatment for exercise: Albuterol MDI 2 puffs or ☐ Yes ☐ No

_____

Other Medications:	Dose:	Route:	Frequency:	To be given at school:
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

5. Allergies (Food Allergies please include a Food Allergy Action Plan) _____

_____

6. Is there a history of learning difficulties? ☐ Yes ☐ No

   If yes, please explain _____

_____

7. History of emotional/behavioral disorders? ☐ Yes ☐ No

   If yes, what is current mental health diagnosis? _____

_____

8. Individual or family psychotherapy indicated? ☐ Yes ☐ No
9. Medical adherence issues? _____
10. Influenza vaccine with parent permission? ☐ Yes ☐ No

I prescribe that the medications are to be given as listed.
I prescribe that the inhaled medications be used with an appropriate spacer.
I agree that the student may receive a dose of Tylenol or Mylanta Q Day PRN.
I am referring this student to Morgridge Academy at National Jewish Health because it is the Least Restrictive Educational Environment to manage their medical needs.
I recommend a flu shot.

_____	_____	_____
Physician Phone Number	Physician's Name (please print)	Date
_____	_____	_____
Physician Fax Number	Physician Signature	Address

MEDICAL STATEMENT TO REQUEST
SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY	2. SITE	3. SITE TELEPHONE NUMBER
MORGRIDGE ACADEMY	1400 JACKSON ST, DENVER, CO 80206	303-398-1488

4. NAME OF PARTICIPANT	5. AGE OR DATE OF BIRTH

6. NAME OF PARENT OR GUARDIAN	7. TELEPHONE NUMBER

8. CHECK ONE:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or registered nurse must sign this form.**

9. DISABILITY OR MEDICAL CONDITION REQUIRING A SPECIAL MEAL OR ACCOMMODATION:

10. IF PARTICIPANT HAS A DISABILITY, PROVIDE A BRIEF DESCRIPTION OF PARTICIPANT'S MAJOR LIFE ACTIVITY AFFECTED BY THE DISABILITY:

11. DIET PRESCRIPTION AND/OR ACCOMMODATION: *(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)*

12. INDICATE TEXTURE:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. FOODS TO BE OMITTED AND SUBSTITUTIONS: *(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)*

A. Foods To Be Omitted	B. Suggested Substitutions

14. ADAPTIVE EQUIPMENT:

15. SIGNATURE OF PREPARER*	16. PRINTED NAME	17. TELEPHONE NUMBER	18. DATE

19. SIGNATURE OF MEDICAL AUTHORITY*	20. PRINTED NAME	21. TELEPHONE NUMBER	22. DATE

*** Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or registered nurse must sign the form.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. A. **Foods to Be Omitted:** List specific foods that must be omitted. For example, the "exclude fluid milk."
    B. **Suggested Substitutions:** List specific foods to include in the diet. For example, "calcium fortified juice."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

DEFINITIONS*:

"A Person with a Disability" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973)