

Information Exchange Form for Children with Health Concerns

Dear Health Care Provider:

We are sending you this Information Exchange Form along with a Consent for Release of Information Form (see back) because we have a concern about the following signs and symptoms that we and/or the parents have noted in this child, who is in our care. We appreciate any information you can share with us about this child in order to help us care for him/her more appropriately, and to assist us to work more effectively with the child and family. Thank you!

To be filled out by Child Care Provider:

Name of Child Care Program: _____

Telephone: _____ Address: _____

We would like you to evaluate and give us information on the following signs and symptoms:

Questions we have regarding these signs and symptoms are:

Date ___/___/___ Child Care Provider Signature: _____

Child Care Provider Printed Name: _____

To be filled out by Health Care Provider:

Health Care Provider's Name: _____ Phone: _____

Address: _____

Diagnosis: _____

Recommended Treatment: _____

Side effects of any medication prescribed that we should be aware of: _____

Should the child be temporarily excluded from care? Yes No

If yes, how long? _____

What should we be aware of in caring for this child at our facility (special diet, treatment, education for parents to reinforce your instructions, signs and symptoms to watch for, etc.)?

Please attach additional pages if needed.

Date ___/___/___ Health Care Provider Signature: _____

Health Care Provider Printed Name: _____

Consent for Release of Information Form

I, _____ give my permission for
(Parent/Guardian)

_____ to exchange health information with
(Sending Professional or Agency)

(Receiving Professional or Agency)

This includes access to information from my child's medical record that is pertinent to my child's health and safety. This consent is voluntary and I understand that I can withdraw my consent for my child at any time.

This information will be used to plan and coordinate the care of:

Name of Child: _____
(Print full name.)

Date of Birth: ___/___/___

Parent/Guardian Signature: _____ Date ___/___/___

Parent/Guardian Name: _____
(Print full name.)

Parents or Guardians signing this document have a legal right to receive a copy of this authorization.

Note: In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable laws, all personal and health information is private and must be protected.

Adapted from: Pennsylvania Chapter of the American Academy of Pediatrics (1993) Model Health Care Policies.
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