

PERMISSION TO RELEASE INFORMATION FROM PHYSICIAN TO PROGRAM / SCHOOL PERSONNEL

You may want your physician to share medical or health-related information with school or program personnel. This form gives written permission for your child's physician to release information to school or program personnel.

I do hereby authorize release of information to:

Name / Institution _____

Address _____

City, State, Zip Code _____

Phone number _____

Student's name _____ Date of birth _____

Information Requested by School Health Nurse

In order to develop an Individualized Health and / or Individual Education Plan as well as to facilitate continuity of treatment for this student, it is important to obtain the following information:

	Parent / Guardian Initials		Parent / Guardian Initials
<input type="checkbox"/> Diagnosis	_____	<input type="checkbox"/> Laboratory tests	_____
<input type="checkbox"/> Date seen by physician(s)	_____	<input type="checkbox"/> Neurological evaluation	_____
<input type="checkbox"/> Treatment and progress	_____	<input type="checkbox"/> Physical examination	_____
<input type="checkbox"/> Prognosis	_____	<input type="checkbox"/> Physician orders for	_____
<input type="checkbox"/> Recommendations for handling	_____	procedures at school	
this health need at school		<input type="checkbox"/> Psychiatric evaluation	_____
<input type="checkbox"/> Discharge summary	_____	<input type="checkbox"/> Psychological evaluation	_____
<input type="checkbox"/> Information observation /	_____	<input type="checkbox"/> Treatment plans / plan	_____
progress notes		of management	
<input type="checkbox"/> Other: _____	_____		

This information is confidential and may only be viewed by the following personnel directly involved in the welfare of my child (please specify, e.g. my child's teacher, principal, persons in the Department of Special Education):

Initials	Parent / Guardian
Name: _____	Position: _____
Name: _____	Position: _____
Name: _____	Position: _____
Name: _____	Position: _____

This information remains in a secured location in the school health service office. It may also be filed in:

Child's cumulative record

Other (please specify): _____

Parent / guardian signature

Date