

**NAME AND ADDRESS OF SCHOOL AND
SCHOOL DISTRICT HERE**

**Authorization to Release Personal Medical
Information to the School Nurse**

I authorize the exchange of medical information related to my child, _____,
Child's Name / DOB
about the specified diagnosis below. I authorize the exchange of information to occur between the School
Nurse and my child's health care provider, _____. I understand
Provider Name
this release is in effect as long as my child remains in this school, and that the release may be revoked at any
time with a written request to my provider AND the school nurse.

Name of Parent/Legal Guardian/or student over 18 years of age: _____

Signature of Parent/Guardian,
or Student over 18 years of age: _____ Date: _____

Practice (circle): **RELEVANT PRACTICES LISTED HERE**

Other: _____

Practice Phone # _____ Fax #: _____

Diagnosis: _____

* Medications: _____

Services requested of the school nurse: _____

Dates of needed services: _____

School Name: (circle): **RELEVANT SCHOOL NAMES LISTED HERE**

Name of School Nurse (see back): _____

Follow-up from School Nurse:

Please call/ fax me at _____ for follow-up by _____
(Date)

No follow-up needed.

* Note: This form does not serve as a medication order form.

