AUTHORIZATION TO RELEASE HEALTH INFORMATION
West Jasper School District

_____ _____
NAME OF STUDENT DATE

I authorize the release of medical information from the school nurse to the health care professionals listed below.

_____ _____
Name of School Nurse
_____
Name of Health Care Professional(s)

I also authorize the release of information from these health care professionals to the school nurse at West Jasper School District for the purpose of:

1. Obtaining legal medical orders for medications, treatments, and other necessary medical procedures that are required during school hours by the school nurse or trained staff.
2. Diabetes Medical Management Plans
3. School Asthma Plans
4. Food Allergy & Anaphylaxis Plans
5. Other: _____

I authorize the school nurse to release my child's pertinent medical information to West Jasper School district staff. I understand this information will be used by those staff members to help assist my child in managing their medical conditions throughout the school year.

_____ _____
Parent/Guardian Date

_____ _____
Witness Date