**Health Office**
School Nurse

Kristin Denning, RN BSN.
AISD Head Nurse

Joolan Eom, RN
AISD Assistant Nurse

# PERMISSION FOR SHARING OF STUDENT MEDICAL INFORMATION WITH CONCERNED STAFF AT AISD

**Student Name:** **Grade:**

**Date of Birth:**

**Month/ Day/Year**

The school nurse and school health office, is requesting permission from the student's parent and/or guardian to provide the staff at AISD with information regarding the student's significant medical history. The information shared between professionals will be used to reinforce and supplement the care of the student in the school setting.

**Information to be shared by the school nurse to the grade level teachers and division administration:**

- Student's name and DOB
- Any medical history regarding any allergies such as food allergies, environmental allergies, and medication allergies
- Significant medical history of illness such as asthma, diabetes, or any chronic illness that may affect activity level, such as cardiac disease.

**Information to be released by the School Nurse to the School Cafeteria Staff <u>if Food Allergy:</u>**

- Student's name, Grade Level, Homeroom Teacher if applicable, and School ID picture
- Type of food allergy and reaction

By signing this document, the school nurse, concerned staff members and the parent(s)/guardian(s) understand that information will be kept confidential between them. Information is not to be shared with any other individuals.

___ I give permission for the school nurse to provide this information to the necessary AISD staff members

___ I do not give permission.

_____ _____

Parent/Guardian Date

_____ _____

Parent/Guardian Date

_____ _____

School Nurse School Nurse