

Parental Permission and Release of Medical Information:

- As parent/guardian of above student, I consent for the employees of AMSACS to follow the plan and use the designated medications on my child in accordance with the instructions above.
- I understand that I am to provide the school with medication and signed authorization form, supplies, etc. to follow the plan.
- I understand that this plan will be shared to all those who need to know (all student's teachers/office personnel/ bus driver/ emergency responder, etc) unless written objection is stated on this form
- I hereby acknowledge that I have read, understand, and support the Emergency Health Plan.

Release of Medical Information

- I hereby authorize my child's health care provider to release to the school nurse, principal, or other authorized school personnel, specific confidential medical information contained in my child's record regarding his/her medical condition. Only school staff delivering health care services to my child in school will use this information.

Parent/ Guardian Signature

Date

Providers Signature

Date

Phone

Nurse Signature

Date