Last Name:	First Name:	Middle Name:	Grade	Date of Birth:	ID#

Parent(s)/Guardian(s) are required to enter emergency contact information on the Infinite Campus Parent Portal at www.hasdtigers.com. For medical concerns, contact will be made according to the phone numbers listed.

MEDICAL CONDITIONS: (✓) AND BE SPECIFIC

_____Diabetes _____Seizure Disorder _____Heart Condition _____Ulcer _____Asthma _____Insect Bite
_____Hyperactivity _____Other **(Describe):**

ALLERGIES TO: (✓) AND BE SPECIFIC

_____Pollens _____Foods _____ Medications _____ Bee Stings _____Other **(Describe):**
List food or medication allergies here:

_____

Does your child take medication at home? _____No _____Yes ****If Yes, please list:

Does your child need to take daily medication during school hours? _____No _____Yes ****If Yes, complete the additional medication permission form and return it to school with your child the first day of school.

Doctor Name: Doctor Phone: ____-____-____ Hospital Name:

Non-Prescription Medication Permission / Medication provided: **Tylenol/Acetaminophen, Motrin/Ibuprofen and Tums/Antacid**
Medications will be administered as directed by manufacturing company. **Parental permission:** I hereby give my permission for the school nurse or other designated person to administer **Tylenol/Acetaminophen, Motrin/Ibuprofen and Tums/Antacid** to my child or to assist in self-administration as requested by the parent to my child. I agree to release the Hollidaysburg Area School District and its personnel from any and all liability of my child taking this medication, and for damages my child may suffer as a result of this request. I understand that the school, can in no way, accept responsibility for the administration of any medication to my child, nor for any condition resulting from the child's failure to procure such medication and for the administration of the medication to the child by the school staff.

_____ _____
Parent/Guardian Signature **Date**

HIPPA AUTHORIZATION FOR DISCLOSURE OF EMERGENCY MEDICAL INFORMATION

I, _____(print name), am the parent or legal guardian of an un-emancipated minor. I represent that I have the capacity to make this
authorization for the use or disclosure of the protected health information of _____(print student name).
I hereby authorize Hollidaysburg Area School District to use and/or disclose the following protected health information
(describe your student's life-threatening medical condition in detail below – for example: asthma, diabetes, bee sting or food anaphylaxis).

1. The person(s) authorized to use or disclose this protected health information are HASD school nurses and administrators.
2. The person(s) to whom the personnel identified in #1 above may disclose this protected health information are HASD staff members involved in my student's care and who could avoid or assist in a life-threatening situation by knowing the information described above.
3. The purpose of this use or disclosure of protected health information is to assist my student in the event of a medical emergency.
4. **The authorization is valid from 8/24/23 until 6/30/2024.**

NOTICE OF IMPORTANT RIGHTS

You have the right to revoke this authorization at any time. In order to revoke this authorization, you must notify the Hollidaysburg Area School District in writing of your revocation. Your revocation will be effective immediately upon receipt by the Hollidaysburg Area School District of your written notification, except to the extent that the Hollidaysburg Area School District has acted in reliance on your authorization.

The Hollidaysburg Area School District may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign the authorization, except that the Hollidaysburg Area School District's group health plan may condition enrollment in the health plan or eligibility for benefits on the provision of an authorization requested by the Hollidaysburg Area School District's group health plan prior to your enrollment in the health plan for the purpose of underwriting or risk rating determination.

The protected health information used or disclosed in accordance with this authorization could be re-disclosed by the recipient and no longer protected by the privacy policies of the Hollidaysburg Area School District or the requirements of the Health Insurance Portability and Accountability Act of 1996.

My signature below acknowledges that I have read the Notice of Important Rights and that I agree to authorize the use or disclosure of protected health information, in accordance with the terms and conditions of this authorization.

_____ _____
Parent/Guardian Signature **Date**