Santa Fe ISD Health Services

Consent of Medical Information

Student Name _____ **DOB** _____ **Grade** _____

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____

School Requesting Information

Campus Name _____ **Phone** _____

Address _____ **Fax** _____

City _____ **State** _____ **Zip Code** _____

Contact Name _____ **Phone** _____

Purpose: to provide medical knowledge and appropriate medical care while in school

Records Requested: ☐ Medical/health records ☐ Vaccination records ☐ Other _____

Facility/Physician Information

Facility Name _____ **Phone** _____

Address _____ **Fax** _____

City _____ **State** _____ **Zip Code** _____

Physician Name _____ **Contact Number** _____

To be completed by parent/guardian/adult student

Yes	No	
☐	☐	I have been fully informed and understand the school's request for my consent, as described above. This information will be disclosed/requested upon receipt of my written request.
☐	☐	I consent to communication between the above health care provider or clinic, the school nurse, the school counselor, or any other school employees acting on behalf of my student's educational and medical needs.
☐	☐	I understand that this consent is voluntary and may be revoked in writing at any time. Unless otherwise revoked, this authorization is valid one year from the date of signature.

Parent Name _____ **Signature** _____

Contact Number _____ **Date** _____