Calallen ISD
Health Services

STUDENT NAME _____ **GRADE**_____

Parent/Guardian:

Below is a regulation regarding the consent to contact your child's health care provider if needed, in order to better provide school health related services. In order to begin or continue to provide this service to your child, this consent must be on file. The regulation is provided below. Please sign and return this document to the school nurse, so we can provide continuity of care to your child.

Regulation

Consent to communicate with medical health care professional or health care provider:

"Written consent must be obtained from a student's parent/guardian allowing the District's designee, including District medical professionals, to share/obtain a student's health related information with the medical health professional or health care provider identified by the parent/guardian, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other CISD form requesting school health care services. School related health services will not be provided to a student without the required consent of the parent/guardian, as outlined herein."

Consent

I consent for the District's designee, including District medical professionals, to share/obtain my student's health related information with the medical health professional or health care provider identified below, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other CISD form requesting school health care services. I understand that school related health services will not be provided to my student without my required consent, as outlined herein.

Thank you.

Parent/Guardian:

Printed Name _____
Signature _____Date_____

Email Address _____Phone/Cell Number _____

Provider Information:
Student's Health Care Provider _____Phone_____
Student's Health Care Provider _____Phone_____
Student's Health Care Provider _____Phone_____