



Walnut Bend Independent School District

47 County Road 198
Gainesville, Texas 76240
www.walnutbendisd.net

(940) 665-5990
(940) 665-9660 fax

Ken Kemp, Superintendent
ken.kemp@walnutbendisd.net

Parent/Guardian:

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

Lj pèz] ér~| þ

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 Walnut Bend ISD 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 here."

*~| ãj | ép

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 Walnut Bend ISD 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 here.

Thank you.

Student's Name: _____ ID#: _____

Parent / Guardian Printed Name: _____

Parent / Guardian Signature: _____ Date: _____

Email Address: _____ Phone/Cell Number: _____

Provider Information:

Student's Health Care Provider: _____ Phone: _____

07/2024