Judson Independent School District

School Health Services

Consent for Release of Confidential Medical Information

Student Name ______ Date of Birth ______ Campus ______ Grade ______

I authorize the following individual(s):

(Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, etc.)

(Street Number, Post Office Box, Route Number) (City, State) (Zip)

To release the following specific confidential information:

☐ Yes ☐ No	Current Health Conditions
☐ Yes ☐ No	Medical History Summary
☐ Yes ☐ No	Current Medication List
☐ Yes ☐ No	Immunization Record
☐ Yes ☐ No	Vision and Hearing Screening Results
☐ Yes ☐ No	Permission for ISD Health Services Staff or Administrator to talk with medical personnel
☐ Yes ☐ No	Test Results:
☐ Yes ☐ No	Other:

To the following individual(s):

(Name or Position of Individual/Organization, if any, represented

(Street Number, Post Office Box, Route Number) (City, State) (Zip)

Purpose of Disclosure:
Educational planning, programming and student safety.

I understand that: 1) my consent is voluntary; 2) I may revoke this authorization in writing at any time; 3); and 4) this information will be released/requested upon receipt of my written consent.

This authorization will expire:

☐ at the end of the current school year, or
☐ one year from the signature date

(Signature of Authorized Person)

(Print/Type Name of Person Authorized to Consent to Release of Information)

Date