



# Stephens County School System

*Schools Committed to Student Success*

**Administrative Offices**  
191 Big A School Road, Toccoa, GA 30577  
(706) 886-9415

## MEDICAL AUTHORIZATION FOR PERSONAL ELECTRONIC DEVICE DURING SCHOOL HOURS

### PARENT/GUARDIAN TO COMPLETE THIS SECTION

STUDENT/PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

School Plans on File (check all that apply): IEP/Special Education  Yes  No IEP Includes Nursing  Yes  No

Section 504 Plan  Asthma Plan  Allergy Plan  Diabetes Management Plan  Seizure Plan  Health Plan

PARENT/GUARDIAN STATEMENT: I hereby authorize my medical physician or provider to exchange health and educational information with Stephens County School System authorized employees (School Administrators and School Nurses) for one year or as otherwise specified. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the LEA may no longer be protected by HIPAA, but they will become records protected by the Family Educational Rights and Privacy Act (FERPA).

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### **PHYSICIAN'S/ADVANCED PRACTICE PROVIDER STATEMENT – This section must be completed by the provider.**

It is my professional opinion that the student/patient needs to be exempt from Stephens County Board of Education Policy JCDAF: Use of Electronic Devices by Students due to the following medical condition(s):

\_\_\_\_\_

Type of electronic device(s) required for the student's medical plan: \_\_\_\_\_

Physician's Special Instructions for Usage: \_\_\_\_\_

The student has been fully instructed on how to use the device for medical needs: \_\_\_\_\_ YES \_\_\_\_\_ NO

The student will need daily and/or periodic assistance from the School Nurse: \_\_\_\_\_ YES \_\_\_\_\_ NO

Physician/Advanced Practice Provider Name: \_\_\_\_\_

Physician/Advanced Practice Provider License Number: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician/Advanced Practice Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_