



UNION COUNTY VOCATIONAL - TECHNICAL SCHOOLS

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Nurse's Office

INFORMED CONSENT & DISCLOSURE AUTHORIZATION

Union County Vocational-Technical Schools | School Nurse's Office

1. STUDENT IDENTIFICATION

Full Name: _____ Date of Birth: _____

School Site: AAHS AIT APA MHS UCT UCCTI AGL

2. DEFINED MEDICAL CONDITION

The following condition has been identified for this student. This is the specific information that will be shared with designated staff if permission is granted below:

DIAGNOSIS / HEALTH HISTORY:

3. PARENTAL CONSENT SELECTION

Teachers and staff need this information to recognize symptoms and provide immediate care. Please select your preference:

YES – PERMISSION GRANTED

I authorize the School Nurse to share the condition listed above with my child's teachers and necessary school personnel. This information is to be used **strictly for safety and emergency response purposes.**

NO – PERMISSION DENIED

I do not authorize the sharing of this health information. I understand that school staff may not be aware of my child's specific medical needs in the event of an emergency.

4. AUTHORIZATION SIGNATURE

Parent/Guardian Signature

Date

Printed Name

Primary Phone
