AMHERST COUNTY PUBLIC SCHOOLS

Parental Permission to Disclose Student Medical Information

Student:_____ DOB:_____
School: _____ Grade: _____
Parent: _____
Address: _____
Phone: (H) _____ (W) _____(C) _____

I, _____, parent/guardian of _____, give my permission to share medical information regarding my child's medical condition of _____ with the following school staff:

□ Principal/Assistant Principal
□ Classroom Teacher(s)
□ Support/Resource Staff (School Counselor, Speech Therapist, Student Accountability Coordinator, School Psychologist, etc)
□ Cafeteria Staff
□ Custodial Staff
□ Classmates
□ Bus Driver/Transportation
□ Other _____

I understand that the information to be disclosed will consist of

*Identification of the medical condition
*Description of associated symptoms and possible side effects
* Procedures to be taken in case of emergency

Confidentiality Statement (to be signed by school staff):

I understand that the information shared with me regarding this student's medical condition is confidential and my not be shared with any unauthorized persons.

Name: _____ Date: _____
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