OLNEY ADVENTIST PREPARATORY SCHOOL

Health Information Release Authorization
2011-2012

Student Name_____ **Date of Birth**_____

I hereby authorize Olney Adventist Preparatory School nurse to share health information and health history with other staff members on a need to know basis. This includes the student's homeroom teachers and teaching specialists that have the student in their classroom. The purpose of this disclosure is for the teachers to be prepared in advance for any medical emergencies.

The health information to be disclosed will be from the Health Inventory, Emergency Information Card, Medical Protocols, Medical Order Form, and Immunization records.

I also authorize release of medical information to _____(name of doctor) for the treatment of my child while attending Olney Adventist Preparatory School.

This medical information will be from the health record that is maintained in the health room by the school nurse.

Authorization

This authorization is valid for one school year (August 15, 2011 to June 01, 2012). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this authorization for release of information is to assist with the treatment of my child. I further understand that this information is released to help in the treatment of my child while attending Olney Adventist Preparatory School.

_____ _____
Parent or Guardian Date

_____ _____
Student Name Teacher

04/27/11