

**Medical Diagnosis(es) Confirmation Form**  
Utah Department of Health & Human Services

**STUDENT INFORMATION**

<b>Student:</b>	<b>DOB:</b>	
<b>Parent/Guardian:</b>	<b>Phone:</b>	
<b>Physician:</b>	<b>Phone:</b>	<b>Fax:</b>

\*Kauri Sue Hamilton School Phone: 801-567-8500 Fax: 801-567-8522 Email: [kshs.nurses-uc@jordandistrict.org](mailto:kshs.nurses-uc@jordandistrict.org)

**PARENT**

*As parent/guardian of the above named student I give permission for communication between my student's health care provider and the school nurse if necessary for planning the care while my student is in school. I understand that the information contained in any resulting healthcare plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.*

Parent Name (print):	Signature:	Date:
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**HEALTHCARE PROVIDER**

As the above named student's healthcare provider I confirm the student has the following medical diagnosis(es): ~OR~ See attached History and Physical

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

<b>Provider Name (print):</b>	<b>Provider Signature:</b>
Phone:	Date:

School Nurse:	Signature:	Date:
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