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

STUDENT INFORMATION		
Student:	**DOB:**	
Parent/Guardian:		
Phone:	**Email:**	
Physician:	**Phone:**	**Fax**
School Nurse Name:	**School Nurse Signature:**	

*__Kauri Sue Hamilton School__ **Phone:** 801-567-8500 **Fax**: 801-567-8522 **Email:** 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:

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 ☐	
Provider Name (print):	Phone:
Provider Signature:	Date: