

**JORDAN SCHOOL DISTRICT NURSING SERVICES
REQUEST FOR SPECIAL HEALTH CARE SERVICES
AND RELEASE OF CONFIDENTIAL INFORMATION**

Student Name	Date of Birth	Parent or Legal Guardian Name
Address	City, State, Zip	
Phone (home/mobile)	Email	
School	Teacher	Grade

Request for NEW Health Care Plan

Update/Re-evaluation of Current Health Care Plan

Please describe the student's medically diagnosed condition and the service and/or treatment you are requesting to be administered by school personnel. Requested services must be medical necessary during school hours.

Specific information to be released:

_____ Two-way Communication _____ Progress Notes _____ Discharge Summary _____ Other _____

I authorize the release of the above named student's health information (as designated below)

From (Physician): _____ To: Jordan School District Nursing Services/Agency
 Phone: _____ Nursing Services

- I hereby indicate that I am the parent or legal guardian of the above named student and that I am requesting that Jordan District personnel administer the health care services described above.
- I understand that someone other than a licensed nurse, in accordance with the Utah Nurse Practice Act, may administer health care services.
- I further understand that health care services will not be provided by Jordan School District personnel prior to the submission of a primary health care provider's statement, if requested, and the development of a Health Care Plan by a Jordan School District nurse in conjunction with communication with the licensed health care provider, as needed. I may be required to supply additional information or forms.
- I understand that the health care provider is not responsible for any further disclosures of the released information by the school/district. I also understand that the released medical records may become part of the student's educational records and may be forwarded to another school in which the student seeks or intends to enroll. The school and district will protect this information in compliance with the Family Educational Rights and Privacy Act (FERPA).
- Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records and permission to communicate with the student's licensed health care provider may be required in order for the school to implement an appropriate plan of education, learning accommodations, and educational modifications. Additionally, permission to communicate with the student's licensed health care provider will be required in order to enable school nurses to provide health care services.
- I understand that if I authorize release of the above information to any individual or entity that is not legally required to keep it confidential, the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996, or any other state or federal law.
- I understand that I have a right to receive a copy of this form after signing and I may inspect the information that is disclosed. By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions and understandings above.
- This authorization shall remain in effect for twelve (12) months from the date of signing. I understand that I have the right to revoke this authorization to the school and student's physician on behalf of my minor child by providing written notice to the health care provider consistent with the health care provider's policies. Revocation does not affect release of medical records made prior to the revocation.
- By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions and understandings above.

Parent or Legal Guardian's Signature

Date

Witness (If required) Date

Witness (If required) Date

Copy to Parent _____ (initial)