GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

School Health Program

Authorization for Release of Information and Consent to Request Information

Student Name_________________________________ DOB________________

ID#___________________ School_____________________________________

Parent/Guardian Name_____________________________ Phone____________

I understand this information will be considered confidential and will be used only to maintain an up-to-date health record. Selected personnel will be informed of any medical deviation which may affect school learning or school attendance.

I authorize: Name ______________________________________

Address_____________________________________

Phone______________________________________

_________ to release to Goose Creek CISD
_________ to request information from ________________________________

The following information is requested:
_________ Health History
_________ Physical Exam Report
_________ Immunization Records
_________ Other (specify)____
____

Information received will be used for one or more of the following:

- Facilitate evaluation of student's individual educational program.
- Determine health needs/special services student may require at school.
- Facilitate health counseling/school health services as requested for student.
- Provide GCCISD personnel with a better understanding of student's health needs.

This consent/release form may be revoked at any time in writing and will be automatically revoked at the end of the school year.

Parent/Guardian signature_____________________________ Date__________
Relationship to student________________________________