Y.A.L.E. SCHOOL

MEDICAL INFORMATION RELEASE FORM FOR SEIZURES

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information regarding my students Seizure Disorder to occur between Y.A.L.E. School Health Services' Nursing Staff as indicated below:

_____ Sending District Case Manager

Initials

_____ Main Office Staff (including administrative staff)

Initials

_____ School Security

Initials

_____ Instructional Staff

Initials

_____ Transportation Staff (To include transportation provided by YALE school only)

Initials

_____ Treating Physician

Initials

My child's healthcare provider (Neurologist) is:

Name of Physician_____ Phone Number:_____
Address_____
_____

STUDENT'S NAME:_____ Date of Birth:_____
School Campus:_____

This authorization is in effect for one calendar school year from this date_____.

Signature of Parent/Guardian: ____