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 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_____

Phone: _____ Attention (District Nurse):_____

- 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. 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 may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.
- 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 of 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)