**AUTHORIZATION FOR RELEASE**

**OF STUDENT MEDICAL INFORMATION**

I hereby authorize the school nurse to release pertinent student medical information pertaining to asthma, severe allergy, diabetes, seizures or other potentially life-threatening medical conditions to the staff members at Hitchcock County Schools who will be involved with my child. I also authorize the school nurse to contact my child’s health care providers for more information regarding these conditions as needed. Medical information may be shared with any administrator, teacher, support staff, bus driver, cafeteria staff, coach, and other staff members involved with my child as deemed appropriate. This will help school staff members to be alert to danger signs and be aware of a need to seek additional assistance for my child if necessary. I understand that no school employee, including a school nurse, administrator, secretary, teacher, paraprofessional, support staff, school bus driver, coach, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission regarding my child’s health*.*

Name of Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_