SEEKONK PUBLIC SCHOOLS

MEDICAL INFORMATION RELEASE FORM

I hereby give my permission for the release of information concerning my child's life threatening allergy to those school employees who come in contact with my child and have a need to know in order to keep him/her safe.

Student's name: ____

Parent/Guardian's name: ____

Parent/Guardian's signature: _____________________________________

Relationship: ____

Date: ____

_____I do not wish for the school nurse to share information about my child's life threatening allergy with other school staff at this time.

Parent/Guardian's name: ____

Parent/Guardian's signature: _____________________________________

Relationship: ____

Date: ____

This form will be kept in the student's health folder. Permission can be withdrawn at any time by notifying the school nurse in writing. If permission is withdrawn, parents become responsible for notifying staff of the student's allergy and the plan of action to be taken should an emergency occur.

Please return this form to the school nurse as soon as possible.