Lafayette County School District

Lafayette County Elementary School
P.O. Box 950
Lewisville, AR 71845

Lafayette County High School
1209 Alexander Lane
Stamps, AR 71860

INFORMED CONSENT- RELEASE OF MEDICAL INFORMATION

TODAYS DATE:_____

STUDENT:_____ **DATE OF BIRTH:**_____

ADDRESS: _____

_____

Under regulations prescribed by Arkansas State Law your consent is required before this school district can disclose confidential information to anyone other than authorized personnel employed by this district.

Information which could indentify an individual child will not be collected or maintained beyond the level of the school district and will not be made available to any state level agency, except for such purposes as overall program monitoring. As a parent you are guaranteed the right to inspect any such information which is subject to collection, to require the accuracy of such information, and to obtain copies. Access by an unauthorized person to information which would identify an individual child, without the informed consent of the parent is expressly forbidden. Parents will be informed in their primary native language or other mode of communication unless it is clearly not feasible to do so. For individuals eighteen (18) years of age or older the above-stated rights pass to the individual.

The school district has the responsibility for the confidential maintenance of this information in locked storage and for the destruction of the information following the termination of services for the child. Parents will be notified prior to the entrance of this information, and prior to the destruction of the data.

Authorization is hereby granted to: School Nurse _____

The following information will be released to a third party:

Lafayette County High School Nurse :_____

(Copy of Last physician visit signed by my childs Physician, Parent/Guardian, and School nurse – Diagnosis and for Medication prescribed to be given during school hours.)

The nurse may fax to my doctor Release of Medical Information form for purpose of receiving return faxed copy from my childs Physician and signed by Physician, Parent/Guardian and School Nurse, Medical Diagnosis and Prescribed Medication information I have checked into school to be given to my child during school hours so that Arkansas School Health Law-- Individual Health Plan (Ark. Code Ann. 6-18-1005) requirements will be met. I understand this is due annually at the start of each school year I check in medication for my child.

I have read and I understand this form. I understand the purpose(s) for which my consent is being requested.

Parent Signature:_____ Date_____

Physician Signature:_____Date_____

Nurses Signature:_____Date_____