Trinity Klein Lutheran Church
Notice for Release/Consent to Request Confidential Information

Student Name: _____ DOB:_____

We are requesting that you authorize Trinity Klein Lutheran Campus Nurse, Sarah Benson RN, to speak with the party specified regarding the above named student and the release or request of specific records containing confidential information regarding the above named student.

Trinity Klein Lutheran Campus Nurse, Sarah Benson RN, has permission to request information from :

Physician Name: _____
Address: _____ Phone Number:_____
_____

Records Requested:

- ❑ Immunizations
- ❑ Hearing/Vision Screening
- ❑ Hearing Records
- ❑ Vision Records
- ❑ Medication Orders for medications to be given at school
- ❑ Diabetes, allergies, and/or respiratory care plans/orders

Name of Person Filling out Form:_____
Relationship to Student:_____
Phone Number:_____

___ Yes ____ No I have been fully informed and understand the school's request for release of the student's records as described above. This information will be released upon receipt of my written request.
___ Yes ____No I understand that my consent is voluntary and may be revoked in writing at any time. Otherwise, this release is valid for one year from the date of signature.

_____

Signature of Parent or Guardian Date

Trinity Klein Lutheran Church
Notice for Release/Consent to Release Confidential Information

Student Name: _____ DOB:_____

I, _____, (parent or guardian) of the above stated student request that Trinity Klein Lutheran Church and School release the below indicated confidential health information:

- ❑ Immunization Records
- ❑ Hearing/Vision Screening
- ❑ Medication Records
- ❑ Accident Reports
- ❑ Incident Reports

This information is to be share in print, fax, or verbally with the below physician and/or his/her clinical staff.

Physician Name: _____
Address: _____ Phone Number:_____
_____ Fax Number:_____

Name of Person Filling out Form:_____
Relationship to Student:_____
Phone Number:_____

___ Yes ____ No I have been fully informed and understand that I am asking for the above confidential information to be shared by the school. This information will be released upon receipt of my written request.
___ Yes ____No I understand that my consent is voluntary and may be revoked in writing at any time. Otherwise, this release is valid for one year from the date of signature.

_____

Signature of Parent or Guardian Date