Chapel Hill Independent School District

School Health Provider Consent

Student Name_____
Date of Birth_____Age_____
Grade_____

I consent for the District's designee, including District medical professionals, to share/obtain my student's health related information with the medical health professional or health care provider identified below, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in my student's IHP, 504 plan, IEP, or other CHISD form requesting school health care services. I understand that school related health services will not be provided to my student without my required consent, as outlined herein.

Authorization

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature. I understand that I may revoke this authorization at any time by submitting a written notice of the withdrawal of my consent.

Date:_____

Parent/Guardian Name (printed):_____

Parent/Guardian (signature):_____

Phone/Cell Number _____

Provider Information:

Student's Health Care Provider _____
Phone_____