

Authorization for Services and Release of Information

Permission for Care

I give permission for the school nurse to perform and carry out the seizure care tasks outlined in the **Seizure** Action Plan/Emergency Action Plan and Individualized Health Care Plan (IHP) designed for my child_____. I understand that no school employee, including a school nurse, a school bus driver, a school bus aide, or any other office or agent of a board of education, shall be held liable for any good faith act or omission consistent with the provisions of (N.J.S.A. 18A:40-12.34 through 12.38).

Student's Parent/ Guardian

Date

Release of Information

I authorize the sharing of medical information about my child, _____, Between my child's physician or advanced practice nurse and other health care providers in the school. I also consent to the release of information contained in this plan to school personnel who have responsibility for or contact with my child, _____, and who may need to know this information to maintain my child's health and safety.

Student's Parent/ Guardian

Date