CANYONS SCHOOL DISTRICT
Request for Special Healthcare Services
School Year: 20   -

STUDENT INFORMATION			
STUDENT:	DOB:	GRADE:	SCHOOL:
PARENT:	PHONE:		

DESCRIPTION OF STUDENT HEALTHCARE NEEDS *Requested services must be necessary during school hours.*	
I authorize two-way communication and the release of the above-named student's health information as designated below:	
Provider Name:	Phone:
To: Canyons School District Nursing Services	Attention (School Nurse):

PARENT/GUARDIAN

- As parent/guardian of the above-named student, I am requesting healthcare services to be administered by Canyons School District personnel and understand that healthcare services may be administered by someone other than a licensed Registered Nurse in accordance with Utah Nurse Practice Act.
- I understand that healthcare services will not be provided by Canyons School District personnel prior to receiving a healthcare provider's statement and medical order, if applicable, and the development of an Individualized Healthcare Plan and other applicable school health plans by a Canyons District School Nurse.
- I understand it is my responsibility to supply Canyons School District Nursing Services with all forms and information necessary to enable the School Nurse to make an initial assessment of the student's health condition. It is also my responsibility to supply Canyons School District with all necessary supplies and equipment necessary for the student's healthcare services.
- This authorization shall remain in effect for twelve (12) months from the date of signing. I understand I have the right to revoke this authorization to the school and student's physician on behalf of my minor child by providing written notice to the healthcare provider consistent with the healthcare provider's policies. Revocation does not affect release of medical records made prior to the revocation.
- I understand that the healthcare provider is not responsible for any further disclosures of the released information by the school/district. I also understand that released medical records may become part of the student's educational records and may be forwarded to another school in which the student seeks or intends to enroll. The school and district will protect all information in compliance with the Family Educational Rights and Privacy Act (FERPA).
- Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and/or health care.
- I understand that if I authorize release of the above information to any individual or entity that is not legally required to keep it confidential, the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996, or any other state or federal law.
- I understand that I have the right to receive a copy of this form after signing and I may inspect the information that is disclosed. By my signature below, I authorize the release and use of the information in accordance with the rights, restrictions, and understandings above.

Parent Name:	Parent Signature:	Date:

SCHOOL NURSE

☐ Request for new healthcare plan ☐ Re-evaluation of current healthcare plan ☐ Medical Diagnosis(es) Confirmation on file

ADDENDUM:

☐ IHP ☐ EAP ☐ DMMO ☐ CGM ☐ PUMP ☐ PUMP/SMART PEN ☐ INJECTION ☐ SMMO

☐ 504 PLAN – DATE: ☐ IEP – DATE: