Highland Park Independent School District

Parent Authorization

STUDENT __________________________ Birth Date _________ Grade/Teacher___________________

Parents ____

Telephone Numbers – Home _____________________ Work ___________________ Cell ___________________

Other Emergency Contact Phone Numbers ____

Doctor _______________________________ Phone ________________ Hospital Preference ______________

Neurologist ___________________________ Phone ________________ Fax __________________________

Please provide the following information on your child:

1. **Type of seizure:** _________________________ **Usual frequency of seizures:** ________________
   Date of last seizure: _______________________ **Seizures started at age:** __________________

   Events which may precipitate a seizure:

   a. ___________________________________

   b. ___________________________________

   c. ___________________________________

   During the seizure, the student will exhibit:

   a. ___________________________________

   b. ___________________________________

   c. ___________________________________

Please list <u>ALL</u> medications taken:

Name	Dosage (amount)	Frequency (how often used)
a. ____________	____________	____________
b. ____________	____________	____________
c. ____________	____________	____________
d. ____________	____________	____________

PARENT AUTHORIZATION

I, ______________________________, request the above health care procedures and/or medication treatment be administered to my child at school. I understand that qualified, designated person(s) will be performing these health care services. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of the procedure/medication(s). I authorize Highland Park School District to use and/or disclose the following above protected health information.

____ Parent/Guardian Signature

___________________________ Date