Nursing Services
Kern High School District
5801 Sundale Avenue
Bakersfield, CA 93309
(661) 827-4532 Office (661) 834-1690 Fax

PHYSICIAN'S AUTHORIZATION TO RELEASE INFORMATION

TO: Parents/Guardians

FROM: District Nurse
Kern High School District

RE: ______________________ ________ ______________
(Name of student) (Birthdate) (School)

To further serve your student, it is necessary that I be able to communicate with your student's physician. All communications are understood to be medically confidential and will be treated as such. It is strictly illegal to share information without your written consent. This authorization shall become effective immediately and shall remain in effect for up to (1) year from the date of parent/guardian signature, but not longer than is necessary to achieve the stated purpose.

I ____ do give my consent
(Name of Parent)
for ____ to share necessary medical
(Name of Doctor)
information about my child with the Kern High School District Nurse.

PLEASE RETURN TO:
District Nurse
Nursing Services
Kern High School District
5801 Sundale Avenue
Bakersfield, CA 93309

Signature ______________________________________ Date ______________
(Parent/Guardian)

Signature ______________________________________ Date ______________
(Student)