1st Cerebral Palsy of NewJersey
Unique needs deserve a unique school

Medical Consent

Date

I ,____, give consent for the physicians caring for my
Parent/Guardian Name. Please Print.

child____, DOB: _______________________________________,
to share medical information including, diagnosis, medications, medical referrals, short and long term treatment plans with the school nurse.

This consent is valid for the school year _______________.

This information will be shared, as needed, with the child study team and teachers in order to provide the best education and a safe environment. I have been advised I may revoke this consent at any time by writing a letter to the school and physicians advising them of my revocation. I am aware that the information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPPA.

Parent, Guardian Signature	Date

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