SECTION 504 MEDICAL RELEASE & DOCUMENTATION

Student DOB

School Grade

Mutual exchange of information and records is required for your child to ensure equal access to school services.

Exchange of information is requested between the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School District and:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records that may be exchanged include:

\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Diagnoses, recommendations, interventions, treatment plans, ratings,

testing data

\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT CONSENT FOR RELEASE OF INFORMATION

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School District and the above named party to exchange information and records. This information encompasses all information pertaining to the minor including protected health information as defined in the Health Insurance Portability and Accountability Act (HIPAA), and education records as defined in the Family Educational Rights and Privacy Act (FERPA).

The purpose of this disclosure is for assisting the school district in offering FAPE pursuant to Section 504 of the Rehabilitation Act of 1973. This authorization expires one year after the date it is signed. Parents may revoke consent at any time by providing written notification to the district.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature Relationship to Student Date

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PHYSICIAN DOCUMENTATION

**(Please have this section completed by your physician and return to the student’s school)**

Alternatively, any physician-signed medical records documenting diagnosis and treatment recommendations would fulfill 504 documentation requirements.

1. What physical / mental impairments (diagnoses) have been identified for this student?
2. What treatments, accommodations, or medications are recommended for this impairment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date