LABBB Health Office at Lexington High School
251 Waltham St. Lexington, MA 02421
Tel: 781-861-2400 ext 1009
Fax: 781-861-1351
Email: healthoffice@labbb.net

HEALTH OFFICE PERMISSIONS for School Year: _____

Please initial and date each statement that you wish to give permission for. If you do not wish to give permission, please do not initial, and put a single line through the statement. Sign and date the bottom and return to the LABBB at Lexington High School Health Office.

Student Name: _____ Date of Birth: _____

_____I understand if my student is off-campus for a field-trip, worksite, physical education, or recreation activities a nurse may not always be available. Every effort will be made for a school nurse to attend field trips during the school day. In the event of an emergency (seizure, allergic reaction, injury), 911 will be called. This is also true for after-school activities where a nurse is not in attendance.

_____I give permission for the LABBB School Nurses and district school nurses to **share health information** with other appropriate LABBB staff members. The staff members may include physical education staff, worksite staff, classroom teachers, and all others deemed appropriate by the school nurses. Every attempt will be made to keep sensitive issues private. Information shared may include, but will not be limited to: allergies, seizure protocols, asthma action plans, emergency diabetes care, etc. This permission will be valid for the school year in which it is dated.

_____ I give permission for the LABBB School Nurses and district school nurses to **contact physicians, nurse practitioners, and other healthcare professionals** providing care and prescriptions for my student. I understand that the purpose of such contact is to better enable the school nurses to plan, develop, and initiate appropriate school health services that will contribute to the safety and care of my child during the school day.

_____I give permission for the LABBB School Nurses to provide treatment to my child should an injury occur during the school day. In the event that I cannot be reached, I also authorize the LABBB nurses to seek further medical treatment on my child's behalf when deemed immediately necessary.

I understand that medical confidentiality of any shared information is guarded carefully, and shared with my child's educational team on a "need to know" basis. I also understand that open lines of communication between my child's Primary Care Providers, medical specialists, myself, and the school nurse are essential for good collaboration of care.

This permission will be valid for the school in which it is dated.

Health Care Providers:

Name: _____ Specialty:_____Phone: _____

Name: _____ Specialty:_____Phone: _____

Name: _____ Specialty:_____Phone: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

Student Signature (if over 18): _____ Date: _____