THE PATHWAY SCHOOL

60th Anniversary

Medical Information Authorization Form

Student's Last Name	First (Preferred)	Middle	Date of Birth

I, the undersigned hereby authorize the school nurses of The Pathway School to use/disclose the following information:

- Medical records of the person identified above, which includes information that may be stored in a paper and/or electronic format.
- I authorize my information to be released including Allergies/Alerts, students name and pertinent medical information to physicians and staff members actively involved with patient care requiring the input of the school nurse.
- Please note this gives the school nurse permission to contact the doctor prescribing medication during school hours.

Family Doctors Name	Address	Telephone & Fax #
Dentist	Address	Telephone & Fax #
Specialist Doctor	Address	Telephone & Fax #

I release the Pathway School from any and all liability arising from the performance of routine medical care and emergency medical care and services between the time the need arises and the time of actual notification. Please note that the school nurse and/or any of the pathway staff will do what is medically necessary in an emergency extending to calling a 911 response. All attempts will be made to contact parents/guardians in this event, however the severity of the emergency will dictate to possibility of this occurring at the time of the emergency.
Should there be the necessity of a 911 responses and or visit to the nearest Emergency Room I also authorize for the release of medical information to the Medical and Emergency response staff involved.

Insurance Company	Name of Insured
Policy Number	Group Number

Once completed this document is in effect until the student exits Pathway, however a form allowing you to update or change the information contained here will be sent annually. It is advised that the information on this document be maintained to reflect the current status for all items mentioned.

Print Name	Print Name
Signature	Signature
Date	Date