Cardinal O'Hara HIGH SCHOOL

RELEASE OF MEDICAL INFORMATION FORM

Student's Name: _____

Date of Birth:___/___/___ Gender: _____

Student's Medical Care Provider: _____

Please describe any medical diagnoses, conditions or problems:

_____

_____

_____

Please identify any allergies:

_____

_____

Please list any medications the student takes:

_____

_____

RELEASE OF MEDICAL INFORMATION:

I give permission for the school nurse to obtain the student's health records (including physical exams, screenings, immunizations and medication orders) from the student's previous school(s) and/or medical care provider(s).

Name (please print): _____

Signature: _____

Date: _____

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