DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Consent to Share Student Health Educational Records

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student educational records. The purpose of this consent is to allow key school–based staff members *(such as the principal, school nurse, nurse case managers, 504 Coordinators, and Special Education staff members)* who work with your child to share health-related educational records with external health-related agencies and healthcare providers, including school-based health centers *(if there is one located in your school)*. These staff members and health care providers would then be able to better coordinate health-related services for your child. Coordinated services will better ensure that your child's needs are met, and that he/she can fully participate in the school's learning environment. **IF YOU AGREE TO THIS CONSENT, PLEASE COMPLETE, SIGN AND RETURN IT TO THE REGISTRAR AT YOUR CHILD'S SCHOOL.**

_____ _____ _____
(Student/Child's Name) (School Name) (Date of Birth)

_____ _____
(Grade) (Student ID, if known)

1. I authorize the District of Columbia Public Schools to share the educational records regarding my child specified in Section 3 below with each of the following agencies and organizations:

*DC Department of Health,
*DC Department of Mental Health,
*DC Department of Health Care Finance,
*DC Department of Human Services,
*Your child's health care provider(s), and
*Other health service providers who deliver services in the school

2. I understand that this information may be used ONLY for the following purposes:

* Planning and providing coordinated educational and health related services, and
* Evaluating programs serving my child and the services provided to my child.

3. I authorize the use/disclosure of each of the following records:

*School nurse records,
* IFSP/IEP documents,
* 504 Plans,
* Class schedule,
* Attendance records,
* Grades, observations and other educational information contained in student records,
* Current Medication orders (retained by the school nurse),
* Eye medical reports,
*Audiology reports, and
*Nursing care plan (as part of IEP or 504 Plan)

4. I understand that:

* This authorization is voluntary and my child will not be refused educational services if I choose not to sign it, and
* I have the right to request a copy of this form after I sign it and to see or copy any information disclosed under this consent.

5. I consent to the use/disclosure of the above information. I understand that this information may not be used for any purposes other than those stated above in Section 2. This consent may be revoked in writing by me at any time. I understand that revoking this authorization will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

_____ _____ _____
(Signature of parent/guardian/student over 18) (Relationship to the student) (Date)

This authorization expires one year from the signature date above.