



300 S Washington
P. O. Box 890
Lexington, Nebraska 68850-0890
(308) 324-4681
(308) 324-2528 - fax
<http://www.lex.esu10.org/>

Date _____

PARENT/GUARDIAN: I give permission for any relevant health information of my child, necessary for
PADRE(S) O TUTOR(ES): DOY MI PERMISO PARA QUE TODA INFORMACIÓN DE SALUD PERTINENTE A MI

educational planning and/or student safety, to be shared among appropriate school personnel who serve the
NIÑO Y NECESARIA PARA LA PLANIFICACIÓN EDUCATIVA O SEGURIDAD ESTUDIANTIL, SEA COMPARTIDA
ENTRE EL PERSONAL DE LA ESCUELA QUE ATIENDE

student (for example; nurses, teachers, coaches, or staff member administering medication).

AL ALUMNO (POR EJEMPLO; ENFERMERAS MAESTROS, ENTRENADORES, O MIEMBRO DEL PERSONAL
QUE ADMINISTRE ALGÚN MEDICAMENTO).

Please have the Dr. fill out this form and have your student return it to the school.

POR FAVOR HAGA QUE EL MÉDICO LLENE Y FIRME ESTE FORMULARIO Y REGRÉSELO A LA ESCUELA.

(Parent/Guardian Signature) (Firma paternal o del tutor)

DR: Today, during examination of _____, we identified the following
concerns:

Please help us with follow-up care of this student, by providing us the following information:

Physician's Findings:

____ No significant findings at this time ____ Child is contagious & should be excluded
____ Need for further evaluation from school for ____ days
____ Re-examination or treatment recommended on (date) _____

Additional comments: _____

Dr. or Dentist Signature _____

Thank You!