TRINITY HALL
Educating and Empowering Young Women in the Catholic Tradition
101 Corregidor Road | Tinton Falls, NJ | 07724 | www.TrinityHallNJ.org

STUDENT MEDICAL HIPAA / INSURANCE

I give permission for my child's health information to be shared with the school faculty/staff and emergency care personnel on a "need to know basis". I recognize sharing this information is important to my child's well-being. I give permission for the School Nurse to speak to my child's health care provider for health information relating to medical information provided. I hereby grant permission to my child's doctor(s) and any other medical care providers to give to the school nurse at Trinity Hall all information pertaining to my child in the possession of the medical care provider. I understand that this information will be shared with my child's teachers and advisors on a "need to know" basis in order to foster the safety and education of my child. I grant permission for this academic year. I understand that I have the right to revoke this permission in writing at any time.

In case of an accident or serious illness, I request the school nurse to contact me. If the school nurse is unable to contact me, I hereby authorize the school to contact the physician listed below and to follow his/her instructions. In the event of a medical emergency when neither I nor my child's physician can be reached, I hereby authorize Trinity Hall, its school nurse, teachers and administrators to take all steps which it deems appropriate, including but not limited to calling 911 or transporting my child to the nearest hospital emergency room.

Parent Signature_____ Date_____

Physician Name _____ Phone Number_____

Physician Address_____ Fax_____

STUDENT HEALTH INSURANCE INFORMATION

Does the Student have Health insurance?

Yes____ Name of Insurance Co._____

No _____ NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 800-701-0710 or visit www.njfamilycare.org

Please release my name and address to the NJ Family Care Program to contact me about health insurance.

Signature_____ Date_____

Printed Name_____

Written consent required pursuant to 20 U.S.C. {1232g (b)(1) and 34 C.F.R. 99.30(b).