Johnston Public Schools

The Johnston Public School Department is committed to the health and safely of students, including during the time they are bussed to and from school. In order to provide emergency care for students with chronic health conditions who may need assistance on the bus, we are requesting your consent to share your child's Emergency Health Care Plan with our bus drivers and monitors during an emergency situation. Please read the following policy and return to your child's school.

1. The parent/guardian will be responsible to notify bus personnel of student condition that may require emergency assistance (such as bee sting allergy, diabetes, etc.)
2. The parent/guardian will be responsible to provide the student with any emergency medication that may be required on the bus (Epi-Pen, inhaler, sugar source, etc.)
3. The school nurse-teacher, in conjunction with parent and health care provider, will develop and Emergency Health Care Plan, based on student's individual condition and needs.
4. A copy of the Emergency Health Care Plan will be stored with the First Student Bus Transportation dispatcher. It will be accessed only in the case of an emergency health episode on the bus.
5. The parent/guardian will complete and sign form below, allowing school to release only necessary health information to First Student Bus Transportation.

Student Name: _____ _____ __ _____ _____
Last First MI Date of Birth Grade

I, the undersigned, do hereby authorize the Johnston Public Schools to provide a written Emergency Health Care Plan regarding the above-named child to First Student Bus Transportation. I understand that this information will be stored in a confidential file with the First Student dispatcher and shared only in the case of an emergency.

DURATION: This authorization shall become effective immediately and shall remain in effect until the end of the current school year. A new consent will be required annually.

RESTRICTIONS: Law prohibits the requestor from making further disclosure of my child's health information unless the requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school nurse-teacher of my child's school.

RE-DISCLOSURE: I understand that the school district will protect this information as prescribed by FERPA. The information will be shared with individuals working at or with the school district for the purpose of providing safe and appropriate care to my child. I have a right to receive a copy of this authorization.

Approval:

_____ _____
Printed Name Signature

_____ _____
Relationship to Student Date