Confidential Student Health Information Access Record

Student Name	*DOB*	*Name & Title of person accessing health record*	*Date of Access*	*Reason for Access*	*Copied or released to:*	*Nature of Disclosure*	*Written Parental Consent*
							❑ Yes ❑ No
							❑ Yes ❑ No
							❑ Yes ❑ No
							❑ Yes ❑ No
							❑ Yes ❑ No
							❑ Yes ❑ No
							❑ Yes ❑ No
							❑ Yes ❑ No
							❑ Yes ❑ No