Holy Trinity School
1325 36th St. NW
Washington, DC 20007
202-337-2339

PERMISSION TO SHARE MEDICAL INFORMATION HTS FACULTY AND STAFF

2019-2020 SCHOOL YEAR

STUDENT NAME: __________________________ GRADE: ____

Throughout the school day and/or during After School, different faculty members supervise your child. Information provided on the Universal Health Certificate and Archdiocesan Medicine Forms is confidential and not shared with the faculty at large. However, your child may have food allergies, insect allergies, asthma or conditions that you would like the faculty/staff to know about.

Significant medical condition/s such as food/insect allergies, asthma, diabetes, etc. that may require medical care at school:

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___ No significant medical conditions

I understand that the information I have provided will be shared with the Holy Trinity School Faculty/Staff.

______________________________________ ______________________

(Signature parent/guardian #1) (date)

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(PRINTED name parent/guardian #1)

______________________________________ ______________________

(Signature parent/guardian #2) (date)

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(PRINTED name parent/guardian #2)