FORM C: FERPA AUTHORIZATION

Student Name:_____ Date of Birth_____

Student ID#:_____

The purpose of this Authorization is to permit Southeast Local School District ("Southeast") to provide all personally identifiable information contained in the student's educational records (including any health-related or other information in the records maintained by the Orrville school nurse) to (i) my parents and/or Legally Authorized Representatives (unless restricted by law) and (ii) Orrville Hospital so that Orrville Hospital can provide telemedicine treatment services to me.

The Family Educational Rights and Privacy Act ("FERPA") is a Federal Law that protects the privacy of student education records. In accordance with FERPA, Southeast will disclose information from education records with the student's, or student's Legally Authorized Representative's, written consent.

By signing this document, I am giving consent that Southeast officials may provide and discuss the entire contents of my educations records, including personally identifiable information from such records, with Orrville Hospital representatives. I understand that I may revoke consent at any time in writing Tara Jacobs, RN, 9050 Dover Road, Apple Creek, Ohio 44606. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization.

_____ Date: _____

Student Signature

_____ Date: _____

Legally Authorized Representative Signature

If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).

_____

6. TECHNICAL OPERATIONS