RELEASE OF INFORMATION

STUDENT'S NAME: ________________________ DATE OF BIRTH: _________

I/WE, THE PARENT(S) OR GUARDIAN OF THE ABOVE NAMED CHILD, AUTHORIZE THE EXCHANGE OF INFORMATION CONCERNING MY CHILD TO THE APPROPRIATE SCHOOL STAFF FOR HIS/HER CARE WHILE ATTENDING SCHOOL.

SCHOOL: ____
ADDRESS: ____
STATE: ______ ZIP CODE: __________ TELEPHONE: ___________

I/WE, AUTHORIZE THE EXCHANGE OF THE FOLLOWING INFORMATION:

- MEDICAL CARE PLAN SPECIFICALLY DEVELOPED FOR MY CHILD BY THE SCHOOL NURSE
- PERMISSION TO SPEAK TO MY CHILD'S TEACHER REGARDING MY CHILD'S HEALTH AND WELL-BEING.

THE INFORMATION EXCHANGED SHALL BE LIMITED TO THAT WHICH IS NECESSARY TO ENABLE THE SCHOOL NURSE AND STAFF TO WORK TOGETHER WITH THE FAMILY AROUND ISSUES OF THE CHILD'S SAFETY, HEALTH AND WELL-BEING, PERFORMANCE, AND ADJUSTMENT TO SCHOOL.

SIGNED: _______________________________________ DATE:_____________

WITNESSED: __________________________________ DATE:_____________