WAYLAND-COHOCTON CENTRAL SCHOOL DISTRICT
Permission to Share Medical Information

Date: _____

I, _____, hereby give the physicians named below permission to share any medical information regarding my child with Wayland-Cohocton Central School.

Child/Student's Name: _____

Date of Birth: _____

1) Primary Doctor: **Name:** _____

Address: _____

Phone: _____

Fax: _____

2) Specialist: **Name**: _____

Address: _____

Phone: _____

Fax: _____

Parent/Guardian Signature: _____