TYLER ISD
HEALTH SERVICES

# RELEASE OF CONFIDENTIAL INFORMATION

Student_____DOB_____ID#_____

School_____Grade_____Date_____

By signing below I give my consent for _____,
(Doctor's Name)
to share confidential information regarding the above named. I understand that this information will only be shared on a need to know basis to ensure the safety of my child and others in his/her educational setting.

_____ _____
(Signature of Parent or Guardian) (Date)