

SCHOOL HEALTH SERVICES

CONSENT FOR RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize the school nurse to communicate as needed with:

Agency/Doctor _____

Address _____

City, State, Zip _____

Telephone _____ Fax # _____

and _____ to communicate with the school nurse and to
(Agency)

release copies of _____ concerning
(Information Requested)

Student _____ Date of Birth _____

Address _____ Zip _____

Name of Parent/Guardian _____

PLEASE MAIL or FAX REQUESTED INFORMATION TO:

School Nurse _____ Phone _____

School _____

Address _____

City, State, Zip _____

Telephone _____ Fax # _____

I understand that the information provided will be used to evaluate the health status of this student on an individual basis and to help in providing a program of health and educational management.

I understand that this authorization will remain in effect from the date hereof to the end of the current school year unless sooner revoked by me at any time in writing.

Signature of Parent/Guardian/Student (if emancipated)

Date signed