



PARENT/LEGAL GUARDIAN PERMISSION TO :
RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

I authorize the Health Office nursing staff to share any health information pertinent to my child's school progress with school personnel and/or other health care providers to which my child may be referred.

Student Name _____ Grade _____ Date of Birth _____
Health Condition/s _____

Please list all names the nursing staff may have contact with.

ALL STAFF OR _____
(please circle) staff name staff name

_____ staff name staff name staff name

_____ staff name staff name staff name

The reason for the disclosure is: ___ student care ___ medical review ___ other _____

This authorization is in effect for one calendar year from today: _____
Date

I consent to release of the above information. I understand that use of this information for any reason other than the expressed reason stated above is prohibited and that disclosure of this information to other parties is strictly prohibited. This consent is subject to revocation at any time.

I completed this form because I am: ___ Student ___ Parent ___ Legal Guardian

Signature of Parent/Legal Guardian Date