MEDICAL INFORMATION RELEASE

Student **Date of birth**

Address

City **State** **Zip**

I, the (parent/guardian) of the student named above,

authorize (name of the school/organization)

to release the necessary confidential health information to the appropriate school representatives including nurse, principal, teacher(s), food service staff, emergency personnel, and applicable volunteers who have a need to know my child's health information to provide safety at school.

Information to be released includes the following (check if applicable):

- ☐ Health record
- ☐ IHP or ECP/FAAP or 504/IEP
- ☐ LTFA and asthma history
- ☐ Social worker/counselor report
- ☐ Psychological/psychiatric evaluation
- ☐ Parent/guardian contact information
- ☐ Other:

I understand that signing this form is voluntary, and it will be used only for the specific information authorized for release regarding my child to specified party, as designated above.

STUDENT SIGNATURE DATE

PARENT/GUARDIAN SIGNATURE DATE

WITNESS SIGNATURE DATE