

Student Health Services
Release of Information

STUDENT INFORMATION

SCHOOL:

DATE:

Student Name _____ **DOB:** _____

Parent/Guardian Name _____ Telephone _____

Street Address _____

City _____ State _____ Zip Code _____

INFORMATION RELEASED TO

Name _____ Telephone _____

Position with School System _____

INFORMATION RELEASED FROM

Name _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____

INFORMATION TO BE RELEASED

Circle: Written or Verbal Communication

I understand that I may revoke this consent in writing at any time, except to the extent action has already been taken. This consent will expire at the end of the present school year.

Signature of Parent/Guardian/Student

Date