AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT_____ DATE_____

DATE OF BIRTH_____ AGE / GRADE_____

As the Parent/Guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged among appropriate professional staff involved in the care of the above student. This consent is intended to allow the staff to better serve my child.

_____
Signature of Parent/Guardian

_____
Date