PARENT/GUARDIAN/STUDENT CONSENT FOR MEDICAL RECORD RELEASE

For:		
Student	Date of Birth	
School	Today's Date	
From:		
Physician	Tel	
Address		
City/State/Zip		
Reason for Request:		
To Aid in Health Care Needs		
For Immunization Records		
For the Care of the Diabetic Child		
Other (heart problems, allergies, etc. Please specify.)_		
Mail written information to:		
Personal and Confidential		
Name (School Nurse/Health Aide)		
School		
Address		
City/State/Zip		
School Tel	School Fax	
Signature of Parent/Guardian/Student (if over 18)	Date	
Print Name of Parant/Cuardian/Student (if aver 19)		