

**MEDICAL INFORMATION RELEASE FORM**

**Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

I, \_\_\_\_\_ parent/guardian of student named above authorize \_\_\_\_\_ (name of medical facility) to release medical information from examination on \_\_\_\_\_ (date) to Southern Public School's administration and/or school nurse.

I, \_\_\_\_\_ parent/guardian of student named above authorize Southern Public School to release health related information to \_\_\_\_\_ (name of individual or facility) as requested.

**Information to be released (specify):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date** \_\_\_\_\_