

# AUTHORIZATION OF EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT \_\_\_\_\_

DATE\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

GRADE\_\_\_\_\_

As Parent/Guardian of the above named student, I hereby authorize the release of pertinent information (medical conditions, allergies, and/or 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 valid for the \_\_\_\_\_ school year and is intended to allow the staff to better serve my child.

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Signature of Parent/Guardian

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Date