THE SCHOOL DISTRICT OF PHILADELPHIA

**SCHOOL HEALTH SERVICES**

# CONSENT FOR RELEASE OF INFORMATION

**TO WHOM IT MAY CONCERN:**

I hereby authorize the school nurse to communicate as needed with:

Agency/Doctor _____

Address _____

City, State, Zip _____

Telephone _____ Fax # _____

and _____ to communicate with the school nurse and to
(Agency)

release copies of _____ concerning
(Information Requested)

Student _____ Date of Birth _____

Address _____ Zip _____

Name of Parent/Guardian _____

**PLEASE MAIL or FAX REQUESTED INFORMATION TO:**

School Nurse _____ Phone _____

School _____

Address _____

City, State, Zip _____

Telephone _____ Fax # _____

I understand that the information provided will be used to evaluate the health status of this student on an individual basis and to help in providing a program of health and educational management.

I understand that this authorization will remain in effect from the date hereof to the end of the current school year unless sooner revoked by me at any time in writing.

_____
Signature of Parent/Guardian/Student (if emancipated)

_____
Date signed