

Parent Release for Medical Information

Student's Name: _____ Date: _____

School: _____ Location: _____

I hereby grant permission to the school nurse to contact my child's physician concerning any medical matter pertaining to my child's welfare in school. I hereby grant permission to the school nurse to release all pertinent medical information (medications, concerns, medical conditions, etc.) to the appropriate school staff members that interact with my child _____.

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____

Parent/Guardian Signature

Date