Consent to Release Medical Information

Mesa Public School – Health Services Department

Parent Consent for Release of Information or Medical Records

To Whom It May Concern:
I hereby give permission for exchange of confidential information contained in the record of my child to school personnel.

Name of Child / Student: _____ DOB: _____

Please list names of medical providers, phone and/or FAX numbers and address:

_____

_____

_____ _____
Signature of Parent/Guardian Date

Information Requested

_____

_____

_____

_____

_____

Please return to :_____ _____
School Nurse School

FAX: _____

Address:_____