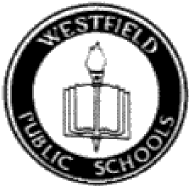

WESTFIELD PUBLIC SCHOOLS
HEALTH SERVICES DEPARTMENT

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information to occur between the School Health Services Nursing Staff and:

NAME: ____PHONE:_______________

ADDRESS:
____

Regarding: _____any or all information

_____specific information regarding___________________________
contained in the record of:

_________________________________ ___________________________________
Name Date of Birth

____
School

This authorization is in effect for one calendar year from today: _______________
Date

Signature of Parent/Guardian: ____

9/21/09