(PARENT)

Hasbrouck Heights Public School
School Health Services

AUTHORIZATION

FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT______________________________ **DATE OF BIRTH__________________**

As the parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, medications and treatment regimes) to be exchanged among appropriate professional staff involved in the care of the above named student.

This consent is valid while your child attends school in the Hasbrouck Heights Public School and is intended to allow the staff to better serve your child. If you have any questions or concerns, please contact my office at the telephone number noted above.

____ ______________________________
Signature of Parent / Guardian Date

________________________________ ______________________________
Print name of Parent / Guardian Telephone Number

Thank you,

The Nursing Department
Hasbrouck Heights Public School

updated 1/23/09