Gloucester City Public Schools
School Health Services

PARENT/LEGAL GUARDIAN
PERMISSION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

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

PHYSICIAN'S NAME:

_____

ADDRESS:

_____

CITY & STATE:

_____

PHONE: _____

Regarding: _____any or all information _____specific information

Regarding: _____

Contained in the health record of:

_____ _____
STUDENT'S NAME DATE OF BIRTH

_____
OTHER NAMES USED

This authorization is in effect for one calendar year from today: _____
DATE

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE