Health Office
School Nurse

Kristin Denning, RN BSN.
AISD Head Nurse

Joolan Eom, RN
AISD Assistant Nurse

aisd American International School Dhaka

Confidential

RELEASE OF INFORMATION

I hereby authorize _____ to exchange
[Name of Nurse], AISD School Nurse

information regarding myself and/or my child with _____
Name

_____
Address **Phone**

This information may be medical, psychological, psychiatric or psychosocial in nature.

Any cancellation or modification of this release of information must be in writing. A photocopy of this authorization shall be considered valid.

The release of information shall be valid until _____

_____ _____
Child's name **Date of Birth**

_____ _____
Parent's / Guardian's signature **Parent's / Guardian's signature**

_____
Parent's address **City** **Zip**

_____
Phone

_____ _____
Witnessed by **Date**

_____ _____
Secondary Witness **Date**
(Required if consent given over phone)