PEQUANNOCK TOWNSHIP PUBLIC SCHOOLS HEALTH OFFICE

Release of Student Medical Information (Confidential)

I_____,
Print: Parent/Guardian Name

parent/guardian of _____,
Print: Name of Student

give permission for the Pequannock Township School Nurses to release medical information to Pequannock Township School District Employees (such as, but not limited to: faculty, staff, coaches) and volunteers on a need to know basis.

The medical information may include, but may not be limited to medical conditions, allergies and medications.

This consent to disclose information is valid for the current school year.

☐ **I *give* consent for the release of medical information.**

☐ **I *do not give* permission for the release of medical information.**

Parent/Guardian signature_____ **Date**_____

Student Grade_____ **Homeroom**_____