



UPPER ADAMS SCHOOL DISTRICT

161 NORTH MAIN STREET, P.O. BOX 847
BIGLERVILLE, PENNSYLVANIA 17307
PHONE (717) 677-7191
FAX (717) 677-9807

PERMISSION TO RELEASE STUDENT INFORMATION

I. Student's Name: _____ Birth Date: _____

Guardian's Name: _____ Telephone _____

School: _____ Grade _____

II. I hereby give permission for _____
(name of organization possessing info. to be released)

to release the information that is initialed below. It is my understanding that all information will be utilized by professional personnel to aid my child in his/her educational program.

III. TYPE OF INFORMATION TO BE RELEASED:

Psychological Evaluation

Physical/Occupational Evaluation

Psychiatric Evaluations

Audiological Evaluations

Educational Data Records

Speech/Language Evaluations

Physicians Reports

Vision Evaluations

Other _____

IV. THE ABOVE INFORMATION IS TO BE SENT TO:

A. _____
(Name) (Title)

(Street Address)

(City)

(State)

(Zip Code)

B. _____
(Name) (Title)

(Street Address)

(City)

(State)

(Zip Code)

Signature (Parent/Guardian/Surrogate Parent) (Address) (Date)

Student Signature (when applicable) (Witness) (Date)