MAMARONECK

PUBLIC SCHOOLS

1000 W. Boston Post Rd.

Mamaroneck NY 10543

914-220-3000

CONSENT TO RELEASE MEDICAL INFORMATION

School: Central ❍ Chatsworth ❍ Mamaroneck Avenue ❍ Murray
❍ Hommocks ❍ High ❍ Other _____

Date: _____

Name of physician/practitioner: _____
Street Address: _____
City/Town; State; Zip: _____
Phone: _____

Name of student: _____
Date of birth: _____

To: Physician/practitioner

Please release any medical documentation and/or other information on the above named patient to the school nurse, and/or the school physician as maybe requested by a representative of the District's Health Office.

_____ _____
Parent/Guardian signature Date

PARENT/GUARDIAN SIGNATURE DENOTES PERMISSION TO SHARE INFORMATION WITH STAFF ON A NEED-TO-KNOW BASIS.