WARREN HILLS REGIONAL SCHOOL DISTRICT
Washington, NJ 07882

MEDICAL INFORMATION RELEASE

Student Name_____ Grade_____

Parent/Guardian is to complete this form and student is to return it to their Homeroom teacher by the second week of school.

☐ My child does NOT have any health issues or medical conditions that need to be shared with Warren Hills faculty and staff.

☐ My child DOES have the following health issue/medical condition that needs to be shared with Warren Hills faculty and staff:

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_____

Family Physician_____ Telephone# _____
Hospital Choice #1_____ #2 _____

I give my permission for the above health/medical information to be shared with my child's teachers and school administration.

_____ _____
Signature of Parent/Guardian Date