CENTRAL YORK
SCHOOL DISTRICT

PERMISSION TO RELEASE STUDENT INFORMATION

Child's Name: _____ DOB: _____

School Building: _____ Grade: _____

Parent/Guardian/Surrogate Parent: _____

Phone Number: _____

I hereby give my permission for the Central York School District to disclose and receive the information that is indicated below. It is my understanding that all information will be used only by professional personnel to aid my child in his/her educational program.

_____ _____ _____
Doctor/Agency/Therapist Address City State Zip Phone

_____ _____ _____
Doctor/Agency/Therapist Address City State Zip Phone

_____ Psychological Evaluations
_____ Psychiatric Evaluations
_____ Educational Data Records
_____ Physical/Occupational Evaluations
_____ Verbal and/or Electronic Communications.
_____ Team Care Checklist

_____ Physician's Report
_____ Audiological Evaluations
_____ Speech/Language Evaluations
_____ Vision Evaluations
_____ Psychiatric Evaluations
_____ Other Checklists (please list)

_____ _____
Signature (*Parent/Guardian/Surrogate Parent)* Date

Address: _____

_____ _____
Student Signature (*when applicable – 14 years and older)* Date

_____ _____
Witness Signature Date

Sent: _____
Received: _____