West Windsor-Plainsboro Regional School District

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information to occur between the School Health Services Nursing Staff and:

☐ All Staff Members who are in contact with my child.

Name: _____ Phone: _____
Address: _____
Regarding: ☐ Any or all Information
☐ Specific information regarding _____

Name: _____
DOB: _____
School: _____

This authorization is in the effect for one calendar year from today: _____
Date

Signature of parent/guardian: _____

Signature of parent/guardian: _____