PARENT RELEASE FOR MEDICAL INFORMATION

STUDENT'S FAMILY NAME: _____ Date: _____

I hereby grant permission to the school nurse at YBH of Passaic to contact my child(ren)'s physician concerning any medical matter pertaining to my child(ren)'s welfare in school. I hereby grant permission to the school nurse to release all pertinent medical information (medications, concerns, medical conditions, etc.) to the appropriate school staff who interact with my child(ren):

_____ _____

_____ _____

_____ _____

PHYSICIAN'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**