Weymouth Public Schools Health Services

Consent for release of medical information to School Nurse

Date:_____

I _____, give my permission to release my child's medical records.

Child's Name:_____ D.O.B._____

Address:_____

Provider's Name:_____

Provider's Phone Number:_____

Provider's Fax Number:_____

Please send information to the school nurse as soon as possible

Parent/Guardian signature:_____

School Nurse:_____ School Name:_____

School Address:_____

School phone:_____ School Fax:_____

Required information:

_____

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