Teacher _____

Grade _____

SURRY COUNTY SCHOOLS
SCHOOL HEALTH PROGRAM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____to release to the school
Physician's Name

nurse or principal specific, confidential medical information contained in his/her record about my child. This information will be used by school staff to deliver health care services to my child at school.

_____ _____
Child's Name Birth Date

_____
Name of School

_____ _____
Parent/Guardian Signature Date

RETURN TO SCHOOL NURSE

Revised 9/2007