JACKSON SCHOOL DISTRICT
151 Don Connor Blvd
Jackson, NJ 08527

(732) 833-4600

PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

Name of Student: _____ Date of Birth: _____

This authorization is in effect for the _____ to _____ school year

I hereby authorize an exchange of medical information to occur between the School Health Nursing Staff and: (please check)

_____ Current teachers for the _____ to _____ school year.

_____ Transportation (if applicable)

_____ Cafeteria (if applicable)

_____ Administration

_____ Guidance

_____ Other _____

_____ _____

Signature of Parent/Guardian Date