Permission to Release Student Information

Child's Name: ______________________________ D.O. B. ____________________

School Building: ___________________________ Grade: ____________________

Parent/Guardian/Surrogate Parent: _______________________ Phone: ________________

I hereby give permission for the Central York School District to disclose and receive the information that is indicated below. It is my understanding that all information will be used only by professional personnel to aid my child in his/her educational program.

__________________________ ____

Name Address City State Zip

__________________________ ____

Name Address City State Zip

____ Psychological Evaluations

____ Psychiatric Evaluations

____ Educational Data Records

____ Physical/Occupational Evaluations

____ Verbal and/or Electronic Communication

____ Physicians' Reports

____ Audiological Evaluations

____ Speech/Language Evaluations

____ Vision Evaluations

____ Other: ________________

____ Checklist __________________________________Write in Name of Checklist

___________________________________ ______________________________

Signature (Parent/Guardian/Surrogate Parent) Date

Address: ____

____ ______________________________

Student Signature (when applicable – 14 years and older) Date

___________________________________ ______________________________

Witness Date