Circleville City Schools

Parent Release Form for Medical Information

I, _____ am requesting the release of information from
Parent Name

_____ to be sent to Circleville City Schools.
Medical Provider Name/School Name

Student Name _____

Student Date of Birth_____

Specific Information to be released:

Immunization record	☐	Written Medication Order	☐
Asthma Care Plan	☐	Physical Exam	☐
Mental or Behavioral Health	☐	Other specified	☐

_____

_____

Parent/Guardian Signature: _____

Print Parent Signature _____

Date _____

Please be advised that information submitted to the school will become part of your student's education record. I further understand that I may revoke this authorization at any time and that upon fulfillment of the above stated reasons, this authorization will expire. In any case, this authorization will automatically expire one year from the date signed.

Please return to:
Circleville City Schools
Jaime McKeivier, BSN, RN, LSN
100 Tiger Drive
Circleville OH 43113
Phone: 740-474-2495, ext. 49099
Fax: 740-477-6681