388 Clark Drive, Circleville, OH 43113

Circleville City Schools

(740) 474-4340 (740) 474-6600 (Fax)

Parent Consent Form for Release of Medical Information

I, (parent name) _____ am requesting the release of information from (Medical Provider name/school name) _____ to be sent to Circleville City Schools.

Student Name_____

Student Date of Birth_____

Specific Information to be released:

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

Parent/Guardian Signature: _____

Print Parent Signature: _____

Date: _____

Please be advised that medical information submitted to the school will become part of your student's education record. Further, by affixing your signature above the undersigned understands that they have the right to revoke this authorization at any time; otherwise, this authorization will automatically expire one year from the date signed above.

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