



PERMIT TO RELEASE MEDICAL INFORMATION

Today's Date: _____

I, _____, (parent's name) give permission for
_____ (my child's health care provider, clinic, dentist, etc)
to exchange and release medical information concerning my child,
_____, to (school nurse, agency, etc.), of Trinity County
Office of Education, so that an appropriate education program can be planned to meet
his/her special health needs.

Child's Name _____ Date of Birth: _____

Parent's Signature: _____ Date: _____

Witness: _____ Date: _____