

**WEST CARROLLTON SCHOOL DISTRICT
CONFIDENTIAL REQUEST
FOR RELEASE OF MEDICAL INFORMATION**

This form has been provided by the West Carrollton School District for the purpose of releasing and obtaining the following student's medical information or records.

Name of Student: _____ DOB: _____

School: _____ Grade: _____

Address of Student: _____

Physician Name: _____

Physician Phone Number: _____

I hereby grant my permission for the West Carrollton School District Nurse to obtain medical information or records from the physician stated above regarding my student for the current school year.

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Date: _____