SANDUSKY CITY SCHOOLS

407 Decatur Street, Sandusky, OH 44870 ● 419.626.6940

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Child's Name _____ Date of Birth_____

As the parent/guardian of above named child, I hereby authorize:

Physician/Agency _____

_____

Physician/Agency Address _____

_____

to release any and all pertinent health information to Sandusky City Schools.

I acknowledge that this information will be used to better understand and care for my child and that all information obtained is confidential.

Parent/Guardian Signature _____ Date_____

Comments:

_____

_____

_____

Physician/Agency: Please fax all pertinent information to:

_____ School

_____

Sandusky, Ohio 44870

FAX: (419) _____

Attention: _____