



AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I, _____ of _____ authorize
(Parent/Guardian) (Address)

Frontier School Division to exchange and release medical information and consult with physician if required for the purpose of developing an Individual Health Care Plan and/or Emergency Plan for

(Student's Name)

I understand as the parent/guardian that I may amend or revoke this decision at any time with written correspondence.

(Parent/Guardian Signature)

(Witness Signature)

(Date)

This contract expires June 30, or when the child leaves Frontier School Division or if there is a change in either custody or legal guardianship, in which case, a new form must be completed.

Note: A copy of this form is to be sent to the Area Special Services Consultant and the original is to be kept in the student's file.

Adopted September 1, 2009		
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