Release of Information

Child's Name _____

I give permission for any representative of the Park Century School staff to speak with the following persons (name of teacher, administrator, psychologist, educational consultant, physician, resource specialist) regarding my child. This information is for the confidential use of school personnel.

Name / Title _____

Email _____

Name / Title _____

Email _____

Name / Title _____

Email _____

Name / Title _____

Email _____ Telephone Number (_____)_____

Comments

_____

_____

_____

Parent's Name _____ Relationship to Child _____

Parent's Signature_____ Date _____