

# 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. Please return this form to Alexandra Pesko, Admission Associate at [apesko@parkcenturyschool.org](mailto:apesko@parkcenturyschool.org).*

Name / Title \_\_\_\_\_

Email \_\_\_\_\_

Name / Title \_\_\_\_\_

Email \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Name / Title \_\_\_\_\_

Email \_\_\_\_\_

Name / Title \_\_\_\_\_

Email \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Comments

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Parent's Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_