Plymouth PUBLIC SCHOOLS
Making dreams come true

School Health Services

_____
Name of School

_____
School Nurse Educator

_____
Telephone / Fax Number

Request for the Release of Medical Information

Date:_____

RE: _____
(Student Name)

Date of Birth:_____

I, _____ parent/guardian of student,
(Name of Parent/Guardian)

Authorize the release of my child's school health records to:

_____ _____
Name **Title/Relationship**

Address to Send Records To (or indicate if pick-up at school)

_____ _____
Parent/Guardian Signature **Date**