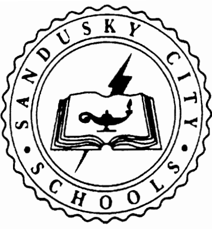

SANDUSKY CITY SCHOOLS

407 DECATUR STREET • SANDUSKY, OHIO 44870

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: ______________________________