Attachment VI
Regulation 757-3

Prince William County Public Schools
Authorization and Consent for Exchange and Release of Medical Information

Student's Name	Student I.D. #	Date of Birth
Parent's/Guardian's Name	Telephone	School

Information obtained on individual students is classified as confidential. Private information cannot be discussed with or released to anyone outside the School Division except as authorized by the parent/guardian.

The undersigned hereby authorizes: Name of Provider_____
Address_____ Phone_____ Fax _____
to release to:
School Nurse: Name of School _____ Address _____
Phone _____ Fax_____ information from his/her health record.

The following information is requested:

_____ Health History

_____ Physical Exam Report

_____ Immunization Records

_____ Other (specify) _____

Information received on your child will be used for one or more of the following:

1. To facilitate evaluation of your child's Individualized Education Program.

2. To determine health needs of your child which may require special services during school.

3. To facilitate health counseling or school health services which you may wish for your child.

4. To provide School Division personnel with a better understanding of your child's health needs.

This authorization may be revoked by you at any time in writing and automatically expires on June 30 at the end of the school fiscal year.

Date	Signature of Parent/Guardian	Relationship to Child

The school is not authorized or funded to pay for this information.