PEORIA
UNIFIED SCHOOL DISTRICT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

COMPLETE IN FULL
Please print

STUDENT INFORMATION	
STUDENT'S NAME	BIRTHDATE
SCHOOL STUDENT ATTENDS	GRADE
PARENT/GUARDIAN INFORMATION	
PARENT/GUARDIAN NAME	PARENT/GUARDIAN PHONE NUMBER

Release the following records:

- ☐ Care Plan/Treatment Plan related to diagnosis
- ☐ Immunization Records
- ☐ Doctor Order for ________________________
- ☐ Other: _____________________________________

DOCTOR INFORMATION	
DOCTOR'S NAME	
NAME OF DOCTOR'S PRACTICE	DOCTOR'S PHONE NUMBER

I give my permission for the doctor listed above to release my student's medical information indicated above to the school nurse or to speak with the school nurse regarding the information.

____ ______________________
Signature of Parent/Guardian **Date**

FOR OFFICE USE ONLY • DO NOT WRITE BELOW THIS LINE

Records should be sent to or discussed with the following school nurse:

SCHOOL NURSE NAME	PHONE NUMBER	
ADDRESS	CITY	ZIP
EMAIL ADDRESS	FAX NUMBER	