Meriwether County School System Health Services
Authorization to Release Information

I hereby authorize: (Please print your physician's information)

_____

_____

_____

_____

to release all available education psychological, immunization, screening and medical information on my child,

_____
Child's Name

_____
Date of Birth

To: _____
_____
_____
Ph _____
Fax _____

for Nursing Assessment and Educational needs.

I understand that the party to whom this information is released will not release it to a third party. I understand and agree to the above statement.

_____
Parent/Guardian Signature

_____
Date