

BUTLER HIGH SCHOOL

38 Bartholi Avenue, Butler, NJ 07405

(973) 492-2000 x281

Authorization for Release and Exchange Confidential
Information

Student _____ Date _____

Date of Birth _____ Grade _____

As the parent/guardian of above named student, I hereby authorize the school nurse of Butler High School to request pertinent medical information that impacts my child's health, safety and educational process. I authorize the release of pertinent medical information to be exchanged among appropriate professional staff involved in the care of the above student. This information will only be shared on a "need to know" and confidential basis. This consent is valid for the _____ school year and is intended to allow the staff to better serve my child.

Signature of Parent/Guardian

Home Phone _____

Cell Phone _____

Work Number _____

