Boone County Schools

School Health Services Department

Consent for Mutual Exchange of Information

Student Name: ____ Date of Birth: ____________________

Parent/ Guardian Name(s): ____

Address: ____

The purpose of this information disclosure is to best meet the student's educational, physical and emotional needs in the academic setting.

Please specify the information being requested below:

____

____

____

____

Disclose records to:	
Name:	
School:	
Street Address:	
City, State, Zip	
Telephone:	
Fax:	

Records may be mailed: ☐ Mailed ☐ Faxed

I certify that I am the parent or legal guardian of the above named child or that I am a student of majority age and have the authority to sign this release.

Signature: ____ Date: ________________________

*This authorization is valid for the current school year only**