

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION



Please <u>ONLY</u> complete if your child meets one of the following:

- □ Receives special education services at school
- □ Requires daily or emergency medications at school
- Requires special procedures to be performed at school (e.g.-tube feeding, catheterization, etc)
- □ Has a chronic health condition, such as asthma, diabetes, seizures, severe allergic reaction, etc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby request and authorize the following to release to the Detroit Public Schools Community District, Office of Student Information Services, medical information regarding my child:

Physician/Medical Facility:			
Phone Number:			
Child Name:	Date of birth:	/	/
I understand that this authorization is voluntary and will expire when my child leaves the district or is terminated by me in writing.			
Parent/Guardian Name:			
Signature:			
Relationship to Child:			
Address:			
Telephone Number:			
Date: / /			

DPSCD does not discriminate on the basis of race, color, national origin, sex, sexual orientation, transgender identity, disability, age, religion, height, weight, citizenship, marital or family status, military status, ancestry, genetic information, or any other legally protected category, in its educational programs and activities, including employment and admissions Questions? Concerns? Contact the Civil Rights Coordinator at (313) 240-4377 or dpscd.compliance@detroitk12.org or 3011 West Grand Boulevard, 14th Floor, Detroit MI 48202.