DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT
Students Rise. We All Rise.

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: / /