WONDER WORLD

1359 Morris Ave, Union, NJ 07083
Tel: (908) 687-2452 · Fax: (908) 687-8507

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Today's Date: _____

Student's Name: _____ Student's D.O.B.: _____

As parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medical regimens) to be exchanged among appropriate professional staff involved in the care of the above named student.

This consent is valid for the _____ School year. It is intended to allow the staff to better serve my child.

_____ _____

Certified School Nurse Parent/Guardian Signature

**** RENEW ANNUALLY ****