

PLEASE SIGN BOTH:

**HUDSON CITY SCHOOL DISTRICT**  
**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**STUDENT NAME:** \_\_\_\_\_

Please Print Clearly

Please forward all medical/immunization records for the above mentioned student to the school nurse at John L. Edwards Primary School.

It is understood that said release shall include only that information that is necessary and pertinent and that all such information will be treated in a professional and confidential manner.

Parent Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Date: \_\_\_\_\_

**HUDSON CITY SCHOOL DISTRICT**  
**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**STUDENT NAME:** \_\_\_\_\_

Please Print Clearly

Please forward all medical/immunization records for the above mentioned student to the school nurse at John L. Edwards Primary School.

It is understood that said release shall include only that information that is necessary and pertinent and that all such information will be treated in a professional and confidential manner.

Parent Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Date: \_\_\_\_\_