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:_____

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