



WillardPublicSchools
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STUDENT INFORMATION RELEASE FORM

Student Social Security #: _____

I give my permission for Willard Public Schools to receive and or share medical, diagnostic and testing information from the person(s) or agency as indicated below. I affirm that I am the parent or legal guardian of

Also, I have been fully informed of the reason and need for this exchange of information. I understand that all information exchanged by these persons or agencies is confidential and will not be disclosed to any other party without the prior written consent of the parent or legal guardian except as permitted by law. Information exchanged by these persons or agencies may be used only for the purpose for which it was released.

Name of person(s) or agency allowed to exchange student information

Reason(s) for which this information is to be released:

PARENT/GUARDIAN Printed Name

SCHOOL OFFICIAL

PARENT/GUARDIAN Signature

TITLE

ADDRESS

SCHOOL

CITY

STATE

ZIP

PHONE

CELL PHONE / WORK PHONE

DATE