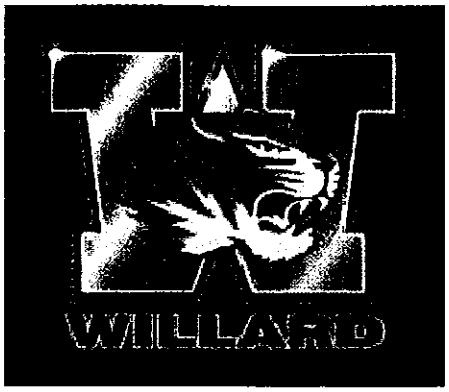

WILLARD R-II SCHOOLS
SPECIAL SERVICES
CARYN MCDONNELL, DIRECTOR
405 FARMER RD
WILLARD MO 65781
417-742-0930 PHONE
417-742-0841 FAX

STUDENT INFORMATION RELEASE FORM

Student Social Security #:_____

I give my permission for Willard R-II 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 SCHOOL OFFICIAL

_____ _____
PARENT/GUARDIAN TITLE

_____ _____
ADDRESS SCHOOL

_____
CITY STATE ZIP

_____ _____
PHONE CELL PHONE / WORK PHONE DATE