EAST RUTHERFORD PUBLIC SCHOOLS
MEDICAL DEPARTMENT

ALFRED S. FAUST SCHOOL
201-804-9694

MCKENZIE SCHOOL
201-531-1235

Authorization for Exchange of Confidential Information

STUDENT_____ DATE_____

DATE OF BIRTH_____ TEACHER_____

As Parent/Guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged among the appropriate professional staff involved with my child. This consent is valid for the 2020-2021 school year and is intended to allow the school staff to better serve my child.

Signature of Parent/Guardian **Date**