Permission to Release
Physician / Health Care Information
Requested Checklist

Child's
Name: _____ DOB: _____

School: _____ Grade: _____

I (we) the parents(s) of _____
hereby request the appropriate officials of the Penn-Trafford School District to complete the attached checklist(s)/information request form and further authorize the release of said information to the requesting healthcare provider listed below.

_____ _____
Parent's signature Date

_____ _____
Parent's signature Date

Physician / Healthcare Provider Name: _____

Address: _____

Phone: _____

Fax: _____

Parent (Guardian) Name: _____

Address: _____

Phone: _____