

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Name of Student: _____ Grade: _____ Date of Birth: _____

I hereby authorize:

Previous School/Agency/Individual:	
Address:	
Address:	
City, State, Zip Code:	
Telephone:	Email address:
Fax:	Website:

To release the information checked below regarding my child to:

Enrolling School/Agency/Individual	Irving Elementary School
Address:	602 W. Jackson St.
Address:	
City, State, Zip Code	Bloomington, IL 61701
Telephone: (309) 827-8091	
Fax: (309) 829-2295	Website: http://www.district87.org

- Cumulative Student Records** (Official transcript grades and tests scores)
- Discipline Records**
- Health Records & Certified Copy of Birth Certificate**
- Special Education Records** (including speech correction, IEP, Psychological report, Social Development Study, Multidisciplinary/Eligibility Conference Reports)
- ISBE** (Form IL Student)
- Other**

Student Signature (if applicable)

Date

Parent/Guardian Signature

Date

Parental permission is no longer required when records are requested by authorized school personnel (Family Educational Rights and Privacy Act, Final Rule on Educational Records, Federal Register, June 17, 1976, Vol. 41, No. 118, Page 24673).

Date requested, mailed, or faxed: _____ By: _____

Records received by and date: _____

Records distributed to: Counselor _____ Team/Teacher _____

Sped Ed (ESC) _____ Case Manager _____ Psychologist _____ Speech Path. _____