

BLOOMINGTON PUBLIC SCHOOLS/School District 87
300 East Monroe Street, P.O. Box 249
Bloomington, Illinois 61702
Phone (309) 827-6031 Fax (309) 828-2917

CONSENT FOR EXCHANGE OF EDUCATION AND HEALTH INFORMATION

Student Name: _____ DOB (Date of Birth) _____

Address: _____

I hereby authorize

School/Agency/Individual/Health Provider: _____

Address: _____

City, State, Zip Code _____

Telephone: _____ Email Address: _____

Fax: _____ Website: _____

The health information to be disclosed consists of:

- Health Records and/or Certified Copy of Birth Certificate _____
 Other (i.e. medical, counseling, etc.) _____

The education information to be disclosed consists of:

- Special Education Records (including therapy reports, IEP, Psychological report, Social Development Study, Multidisciplinary/Eligibility Conference Reports)
 Cumulative Student Records Official transcript grades and test scores
 Discipline Records Other _____

This information will be used for the following purposes(s):

- Educational evaluation and program planning
 Health assessment and planning for services and treatment in school
 Medical evaluation and treatment
 Other: _____

Authorization is valid for one calendar year from the date of signature.

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, will become education records protected by the Family Educational Rights and Privacy act. I understand that I have the right to inspect and copy school records and to challenge the contents of these records.

Parent/Guardian/Surrogate Signature _____ Date _____

Student Signature* _____ Date _____

* If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this form.

Cc: Parent or Student
Physician or other health care provider
School

Office Use Only:
Records sent _____ by _____
Date Name