Academic and Medical Release Authorization

Student's Name: ___________________________Date of Birth: _________

I hereby authorize Walnut Farm Montessori School to received or release information concerning my child with respect to medical history, or copies of hospital and medical records and psychological, medical and educational information. Information received shall be considered confidential. A Photocopy of this authorization shall be considered valid.

Date Signature of Parent or Guardian

Date Signature of School Official

Name and Address of Last School Attended:

School Mailing Address, City State and Zip Code

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