Release of Records Authorization

Brocton Central School
138 W Main Street
Brocton, New York 14716
Telephone: (716) 792-2191
Fax: (716) 792-2233

Date: _____ Date of Birth: _____

Student's Name: _____ Present Grade Level: _____

Former School: _____

Address: _____
(street) (city) (state) (zip) (phone #)

Please release the following information to Brocton Central School for the above named student:

__ Most recent report card	__ Exit Grades	__ Current Schedule
__ Transcript	__ Previous Report Cards	__ Assessment Grades
__ IEP *(if applicable)*	__ 504 *(if applicable)*	__ Attendance Report
__ Conduct Report	__ Immunization Records	__ Medical Records

Please mail a copy of any psychological evaluations to Brocton Central School, attention Special Education Department.

Thank you for your promptness and cooperation in this matter.

_____ _____
(Parent or Guardian Signature) (Date)

_____
(Address) (City) (State) (Zip) (Telephone Number)

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

Brocton Central School

Consent for Release of Medical Records

I consent to have medical records including immunization dates for:

_____

(Child's name)

Date of Birth _____

Release to Brocton Central School by:

1. Chautauqua County Department of Health _____
2. _____

(Private Physician name)

_____ _____

(Signature of Legal Parent/Guardian) (Date)