Southeastern Local School District

Consent for Release of Records

To: (Name of Physician and/or Physician's office):

_____

I am the parent/guardian of:

Name: _____ Date of Birth: _____ Grade level: _____

You are authorized to release any immunization records and/or medication orders to:

Madison Francis, BSN, RN

School Nurse

Southeastern Local School Disctrict

2003 Lancaster Road

Chillicothe, Ohio 45601

Reason for Request (please circle):

School Enrollment Update Student Records

Medication Order Medical History Immunization Record/Update

If other, please explain:

_____

_____

_____

Date: _____

_____

Parent/Guardian Printed Name

_____

Parent/Guardian Signature