

# Barrow County School System

## Medical Information Release and Fax Consent

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*{The purpose of this form is to allow both verbal and written exchange of medical information between the child's/student's school and the child's physician's office.}*  
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As the parent/guardian of a child attending \_\_\_\_\_ School,  
School Name

I understand that the school requires Student Care Plans and/or Medication Consent forms on all students who have special needs which either require that school personnel directly administer care, or supervise the care, being delivered to the student.

I therefore give permission for release of medical information regarding my child,  
\_\_\_\_\_, between the physician's office:

Child's/Student's Name

/ phone # \_\_\_\_\_

Physician's Name

and the above named school. By signing this, I also give permission for the school to consult with my child's physician and to fax any medical information (Student Care Plans, Administration of Medication Request forms [med. consent forms], etc.) to/from either facility as needed.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date