



**Framingham Public Schools**  
Robert A. Tremblay, Ed.D., Superintendent of Schools

**DEPARTMENT OF HEALTH AND WELLNESS**

Ms. Shavonne Lord, Director

19 Flagg Drive

Framingham, MA. 01072

Telephone: 508-626-9197 Fax: 508-877-3243

STUDENT' NAME \_\_\_\_\_

SCHOOL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

GRADE \_\_\_\_\_

**Attached is an authorization for the release of medical information for the student named above.**

**We are in need of this information to determine how best to accommodate the student's health issue in relation to the school environment.**

**Please indicate your consent to release your child's medical information by signing below.**

Sincerely,

**School Nurse/School Physician/Principal**

\_\_\_\_\_  
Authorization to CONSULT PHYSICIAN, HOSPITAL, or CLINIC

**I hereby authorize any physician, hospital, or clinical staff that has cared for my child, \_\_\_\_\_, to release medical information to the Framingham Public Schools School Health Services for its confidential use, as stated above.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Parent/Guardian