



Medical Information Release Permission Form

Please complete and return to the Boals School Nurse's Clinic
By Date: _____

I, _____, (*please **print** your full name*)

Parent or Guardian of _____ (*please print child's full name*)

Please circle your response:

1) Do / Do NOT give permission for the Boals Elementary School Nurses to share information regarding caring for my child's medical condition(s) with appropriate Boals staff members {i.e. my child's teachers, principal, assistant principal}.

Signature of Parent or Guardian: _____

Date: _____