Cincinnati Public Schools
Early Childhood Education

PERMISSION TO OBTAIN CONFIDENTIAL INFORMATION RELATED TO THE MEDICAL/DENTAL EXAMINATION

Program Site: _____ Program Year: _____

Program: _____ Teacher: _____

Child's Name: _____ D.O.B. _____ I.D.# _____

I authorize the Medical Facility/Agency: _____

Address:_____ ZIP _____ Telephone _____

I authorize the Dental Facility/Agency:
_____

Address:_____ ZIP _____ Telephone _____

I authorize the Women, Infants and Children's Program(WIC) :

Address: 7162 Reading Rd, Cincinnati, OH ZIP: 45237 Telephone: 513-821-6813

to release information about _____, for whom I am legally responsible, to the Cincinnati Public Schools Early Childhood Education Program(s). In granting such permission, I understand that such information will remain confidential and protected under The Family Rights and Privacy Education Act (FERPA).

I release the Program(s) and its staff from any legal liability for acquiring this information, which I have authorized by signing this form.

I also release the above named facility/agency from any legal liability for giving information to the program(s) for the period stated above.

This permission is valid for the _____ program/school year.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

White Copy - Child's File Yellow Copy - Parent Copy