

*West Milford Township Public Schools
West Milford, New Jersey 07480*

Office of the School Nurse

**RELEASE OF MEDICAL INFORMATION
CONSENT FORM
Confidential**

Student's Name: _____

I _____
Print Parent/Guardian Name

Please check one:

1. authorize: the West Milford Township School Nurses

*to disclose to: West Milford Township School District
Employees (i.e., faculty, staff, coaches) and Volunteers
on a need to know basis*

*Medical Information from my child's health record (i.e. medical
conditions, allergies, medications)*

*This consent to disclose information will be valid during your
student's entire period of enrollment in West Milford Township
Public Schools. It is the responsibility of the parent/guardian to update this information
annually (i.e., via Emergency Cards) and whenever the student's medical
condition/information changes.*

Parent or Legal Guardian Signature _____

Date: _____

*2. Do not authorize: The West Milford Township School Nurses
And take full responsibility to disclose information to:
West Milford Township School District Employees.*

Parent or Legal Guardian Signature _____

Date: _____