Capistrano Unified School District

PARENT PERMISSION FOR RELEASE OF INFORMATION

CAPISTRANO

STUDENT INFORMATION

Name: First **Middle** **Last** **DOB** **Age** **Today's Date**

Student ID # **Current School** **Current Grade** **Current Program** **Teacher**

I hereby consent to, request, and authorize any and all persons or entities listed below to exchange with Capistrano Unified School District any or all social, psychological, speech/language or educational information regarding the above named person:

1 Name: Address:
Phone: Fax: City/State/Zip:

2 Name: Address:
Phone: Fax: City/State/Zip:

3 Name: Address:
Phone: Fax: City/State/Zip:

4 Name: Address:
Phone: Fax: City/State/Zip:

5 Name: Address:
Phone: Fax: City/State/Zip:

6 Name: Address:
Phone: Fax: City/State/Zip:

7 Name: Address:
Phone: Fax: City/State/Zip:

8 Name: Address:
Phone: Fax: City/State/Zip:

9 Name: Address:
Phone: Fax: City/State/Zip:

10 Name: Address:
Phone: Fax: City/State/Zip:

Please mail or fax to:

Name: Address:
Phone: Fax: City/State/Zip:

A photocopy/facsimile of this document is as valid as the original.
This authorization shall remain effective until revocation in writing has been delivered to said school district.

Parent/Guardian Signature Date Relationship to student

Date Received by District: _____

DRAFT