

STUDENT INFORMATION EXCHANGE FORM

STUDENT NAME :	BIRTHDATE:
ADDRESS:	
CITY/STATE/ZIP:	
HOME TELEPHONE:	

I hereby give permission for Webster Groves School District to:

- OBTAIN the following information from:
- RELEASE the following information from:
- Written Exchange Verbal Exchange Both

Information to be released:

- Medical Psychological Educational Social Psychiatric
- Other (please specify) _____

NAME:	
ATTENTION	
ADDRESS:	TELEPHONE:
CITY/STATE/ZIP:	FAX:

FOR REQUEST TO OBTAIN INFORMATION, please send the above information to:

DEPARTMENT: Bristol Elementary School	ATTENTION: Deidre Townsend, School Social Worker Shawn Crecelius, School Counselor
ADDRESS: 20 Gray Avenue	TELEPHONE: 314-918-4412
CITY/STATE/ZIP: Webster Groves, MO 63119	FAX: 314-963-6438

BRISTOL ELEMENTARY SCHOOL
 20 GRAY AVENUE
 WEBSTER GROVES, MO 63119
 School Office: 314-963-6433 Fax: 314-963-6438

STUDENT INFORMATION EXCHANGE FORM

I (we) understand this authorization is specifically for the records above and is for school-related purposes. I further understand that BRISTOL ELEMENTARY SCHOOL will not release information to any unauthorized person/agency without my written consent. Likewise, I (we) understand that this release may be revoked by me at any time, except to the extent that the party, which is to make disclosures, has acted accordingly. This authorization is valid for a period of **one year** unless otherwise revoked. I (we) hereby release any person, firm, physician, clinic, hospital, or agency from liability for information furnished pursuant to this authorization.

Parent/Guardian (Print Name)

Parent/Guardian (Signature)

Date