



East Rutherford School District
Nursing Department
East Rutherford, New Jersey 07073

McKenzie School
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AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT _____

DATE OF BIRTH _____

DATE _____

TEACHER _____

As Parent/Guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged among appropriate professional staff involved with my child. This consent is valid for the time my child is registered with the East Rutherford School District and is intended to allow the school staff to better serve my child.

Signature of Parent/Guardian

Date