

CONSENT: PARENT AUTHORIZATION MEDICAL RELEASE FORM

Student: _____

Date of Birth: _____

I,

(Parent or Guardian) Please print

Authorize the release of the results of the most recent vision/medical evaluation(s) to the staff of the **Atlantic Provinces Special Education Authority** for the purpose of developing appropriate programming for

My Child:

(Please print)

Doctor's Name: _____

Address: _____

Date **Parent/Guardian Signature**

Parent Address: _____

Return Completed Form to: Health Unit
APSEA
5940 South Street, Halifax, NS B3H 1S6

Serving Children and Youth Who are Deaf, Hard of Hearing, DeafBlind or Visually Impaired