GIBBSBORO ELEMENTARY SCHOOL DISTRICT

Grades PS through 8

AUTHORIZATION TO RELEASE/OBTAIN STUDENT RECORDS

Student Name:_____ Date of Birth:_____

Grade:_____ School Year:_____

Signature of School Representative _____

I hereby authorize:

Gibbsboro School
37 Kirkwood Rd.
Gibbsboro, NJ 08026
c/o Rebecca McFerren
Phone: 856-783-1140
Fax: 856-783-9155
Email: rmcferren@gibbsboroschool.org

To: ☐ Obtain Information/Records from

☐ Release Information/Records to

School: Name: _____

Address: _____

Phone/Fax:_____

I understand the information to be exchanged may include:

☐ Child Study Team Records ☐ Medical Records

☐ School Records/Cumulative Folder

INFORMATION RELEASE AUTHORIZATION

I hereby give permission to release all family, social, medical, psychological, and/or psychiatric information regarding my child to the Gibbsboro School.

Parent Name(print)_____ Relationship to Student: _____

Parent Signature: _____ Date: _____