

AARON DECKER SCHOOL

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James Manco
Principal

**AUTHORIZATION FOR EXCHANGE OF
CONFIDENTIAL INFORMATION**

PLEASE COMPLETE, SIGN AND RETURN TO NURSE

Student _____

Date _____

Date of Birth _____

Grade _____

As parent/guardian of the above named student, I hereby authorize the release of pertinent medical information to be exchanged among appropriate professional staff involved in the care of the above student. This information will only be shared on a "need to know" and confidential basis. This consent is valid for the _____ school year and is intended to allow the staff to better serve my child.

Signature of Parent/Guardian

Home Number

Cell Number

Work Number

Karen Lomascola, RN
Aaron Decker School Nurse