



Parent/Guardian Release of Information

UIC Code: _____ Date: _____

Student Name: _____

Birthdate ___/___/___ Last First Middle
Primary Physician's Name _____

Address: _____ City, State, Zip _____

I hereby authorize the above named source to release or disclose to _____ School District the following information for the student listed above:

- Any known medical or health contraindication for the use of Emergency Seclusion and or Emergency Restraint

I authorize the use of fax, photocopy, and email of this form for the release or disclosure of the information described on this form. I understand that this authorization, except for action already taken, may be voided by me at any time.

Parent/Guardian Signature

Date

Medical Personnel Input

Identify any known medical or health contraindications for the use of emergency seclusion and/or emergency restraint.

Physicians Signature

Date

Physicians Name (please print or type)