CHARLES ARMSTRONG SCHOOL

Release of Information

Child's Name: _____

I give my permission for any representative of the Charles Armstrong School staff, to speak with the following persons (name of teacher, administrator, psychologist, educational consultant, physician, resource specialist) regarding my child:

Name/ Title: _____ Phone:(_____) _____

Name/ Title: _____ Phone:(_____) _____

Name/ Title: _____ Phone:(_____) _____

Name/ Title: _____ Phone:(_____) _____

Comments: _____

_____

_____

_____

_____

Parent's Name: _____ Relationship to child: _____

Parent's Signature: _____ Date: _____