Wild Rose School Division

Board Office: **4912-43rd Street**
Rocky Mountain House, AB
T4T 1P4
Ph: (403) 845-3376
Fax: (403) 845-3850

Consent for Release of Confidential Information

As the parent or legal guardian of _____, (birth date: _____), I hereby give consent to Wild Rose School Division staff to access all medical/psychological/psychiatric information in respect to this student. I understand that this information may be used to: (a) assist with planning adapted or modified programming; (b) provide a classification or clinical diagnosis; (c) assist in decisions regarding special needs eligibility and/or program placement; (d) develop Individualized Program Plans (IPPs) for learning, social and/or behavioral needs including possible support services; and/or (e) make a referral to other outside services.

Exceptions to confidentiality include situations where WRSD is required, by law or professional obligation, to release information or to intervene. These exceptions include (a) possible child abuse/neglect; (b) probable harm to the student, (c) imminent harm to another person, or (d) records subpoenaed by court.

My signature(s) below indicate(s) that I understand the information presented in this form and that I freely consent to have my child's medical/psychological/psychiatric information released to WRSD.

Questions may be directed to the Principal of my child's school or the Student Support Facilitator assigned to provide services to my child.

Student Name: _____ Date of Birth: _____
(Please print)

Parent/Guardian: _____ _____
(Please print) (Relationship to student)

Parent/Guardian: _____ _____
(Signature) (Relationship to student)

Student's signature: _____
(Required if 'independent' student or if student is 18 years of age or older)

Name of Witness: _____ _____
(Please print) (Signature)

Date: _____