Saddleback Valley Unified School District

Parent Permission for Release of Information

Student Information:

First Name	Middle Name	Last Name	DOB	Age

Student ID#	Current School	Grade	Current Program

I hereby consent to, request, and authorize any and all persons or entities listed below to exchange with Saddleback Valley Unified School District any or all social, psychological, medical, speech/language and educational information regarding the above names student:

1	Name:		Address:
	Phone:	Fax:	City/State/Zip Code:
2	Name:		Address:
	Phone:	Fax:	City/State/Zip Code:
3	Name:		Address:
	Phone:	Fax:	City/State/Zip Code:
4	Name:		Address:
	Phone:	Fax:	City/State/Zip Code:
5	Name:		Address:
	Phone:	Fax:	City/State/Zip Code:
6	Name:		Address:
	Phone:	Fax:	City/State/Zip Code:

Please mail/email/fax to:

Name:		Address:
Phone:	Fax:	City/State/Zip Code:
Email Address:		

This authorization shall remain in effect until revocation in writing has been delivered to said school district:

Parent/Guardian Signature	Date	Relationship to Student

Date Received by District: _____

Copy to: File and Parent