

CONSENT TO RELEASE MEDICAL AND EDUCATIONAL INFORMATION

Date \_\_\_\_\_

This is to certify that I am willing that Holgate Local Schools release information concerning:

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name of Parents/Guardians

For the purposes of health care and/or education.

Signed by: \_\_\_\_\_  
Parent or Legal Guardian