CONSENT TO RELEASE INFORMATION FROM SCHOOL

| Child's name: | Birth date (yy/mm/dd): |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| To determine what services your child require preschool. | res, we require your permission to contact your child's school/ |
| Name of school/preschool: | |
| Contact person: | |
| Title/position: | Phone: |
| | egal guardian, consent for the release of any information which by child's school function or development, including written or |
| Signature of parent/legal guardian: | Date: |
| Signature of witness: | Date: |
| Please return this signed consent from and | the completed parent/school questionnaires to: |
| Dr | |
| Address: | |