

WESTLAKE CITY SCHOOLS

ATTACHMENT VII -

RELEASE OF MEDICAL INFORMATION TO WESTLAKE CITY SCHOOLS' PHYSICIAN

Physician/Hospital/Health Care Provider

I, _____, request release
of pertinent medical information to the school physician of the Westlake City Schools.

I understand that all or part of this information may be used by the medical review team in evaluating the
medical status of the above-named person and after medical team evaluation may be shared with the
Superintendent in order for the Superintendent to make appropriate educational decisions.

(Date)

(Signature)

(Relationship)