Naperville 203
Community Unit School District

Christine Igoe
Assistant
Superintendent for
Student Services

Administrative Center **203 W Hillside Road** **Naperville, Il 60540-6589** **630-420-6465** **FAX:630-420-6566**

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I/we hereby authorize the exchange of communications and the release/exchange of the following records concerning

_____ _____
(student's name) (birthdate)

between **Naperville School District 203** agents and employees and:

Name/Title: Janet Daniels, Regional Immunization Representative
Agency/Organization: Illinois Department of Public Health
Address: 245 West Roosevelt Road, Building #5, West Chicago, IL 60185
Telephone: 630-293-6800 E-mail: Janet.daniels@illinois.gov

The following information will be released/exchanged:

☐ All permanent records (including, but not limited to, basic identifying information, academic transcript, attendance records, health records and scores received on all State assessments administered in grades 9-12, where applicable)
☐ All temporary records (including, but not limited to, scores on State assessments administered in grades K-8,discipline records, health-related information, accident reports, aptitude and achievement test results, report cards, progress monitoring information, special education records, and Section 504 records)
☐ All IEP/special education and/or Section 504 records
☐ Other (specify): _____

These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq.,* and are to be made for the purpose of:

☐ Educational evaluation and/or planning
☒ Other (specify): Physician statement of immunity/medical objection, child health examination form

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the student. This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
WITNESS SIGNATURE (for mental health/ DATE
developmental disability records)

_____ _____
STUDENT SIGNATURE (for mental health/ DATE
developmental disability records, if student is age 12 or older)

*** NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (ªHIPAA@).**

SEND RECORDS TO:

District 203 Principal _____
District 203 School _____

District 203 Address