

Sullivan West Central School

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Judy Durkin, SWE Nurse

Danielle DuBois, SWHS Nurse

CONSENT FOR MUTUAL RELEASE OF INFORMATION

I hereby authorize: _____

Healthcare Provider name

Healthcare Provider address

and

Sullivan West Central School
Health Office
Box 308 Schoolhouse Road
Jeffersonville, New York 12748

To share mutually any pertinent information regarding:

Student Name

Parent/Guardian Signature

Date