

BENWAY SCHOOL 2017-2018 SCHOOL YEAR

3.

STUDENT SERVICES FORM

STUDENT NAME _____ DATE _____

PHYSICIAN/CLINIC NAME _____
ADDRESS _____
CITY _____ PHONE _____

PSYCHIATRIST NAME _____
ADDRESS _____
CITY _____ PHONE _____

THERAPIST NAME _____
ADDRESS _____
CITY _____ PHONE _____

DYFS WORKER NAME _____
PHONE _____

PROBATION OFFICER NAME _____
PHONE _____

OTHER INDIVIDUALS WHO WE WOULD BE ABLE TO SPEAK WITH:

NAME _____ RELATIONSHIP TO STUDENT _____

PHONE NUMBER(S): _____

NAME _____ RELATIONSHIP TO STUDENT _____

PHONE NUMBER(S): _____

BY SIGNING BELOW, YOU ARE GIVING YOUR PERMISSION TO BENWAY SCHOOL PERSONNEL TO RELEASE AND EXCHANGE INFORMATION WITH THE ABOVE LISTED INDIVIDUALS WHO ARE INVOLVED WITH YOUR CHILD. THIS WILL ENABLE US TO PROVIDE APPROPRIATE SERVICES TO YOUR CHILD AS NEEDED.

I GIVE PERMISSION TO BENWAY SCHOOL TO EXCHANGE INFORMATION REGARDING MY CHILD WITH THE ABOVE LISTED INDIVIDUALS.

SIGNATURE OF PARENT/GUARDIAN

DATE