# BENWAY SCHOOL
# 2016 - 2017 SCHOOL YEAR

## 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.**

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**SIGNATURE OF PARENT/GUARDIAN** **DATE**