BENWAY SCHOOL
2015 - 2016 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**