Robert Bateman
Secondary School

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____,

(Name of Parent/Guardian – Please Print)

hereby give my written consent to have _____

_____,

(Name and Address of Previous School or Institution – Please Print))

release the student folder, permanent record card and all pertinent medical, psychological, or psychiatric (including social history, all hospital testing and assessments) information which pertains to my child,

NAME_____**DOB:**_____

To: ROBERT BATEMAN SECONDARY
35045 EXBURY AVENUE
ABBOTSFORD, BC V2S 7L1

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise sufficient safeguards while using this information.

Signature of Parent/Legal Guardian:

_____

Address:

_____

Phone: _____

Date: _____