

FISHERS ISLAND SCHOOL
PO DRAWER A
FISHERS ISLAND, NY 06390

CONSENT FOR RELEASE OF INFORMATION FROM OTHER AGENCIES/SCHOOLS
TO FISHERS ISLAND SCHOOL

Date _____

Name of Student _____ DOB _____

Name of Parent(s)/Guardian _____

I give my permission for the release of the following information on the above named student to the **Fishers Island School**:

- Academic Records
- Student Assistance Records
- Special Education/CSE/PPT Records
- Psychological Testing
- Child Study Team Records
- Health & Immunization Records
- Standardized Testing Records
- Section 504 Records
- Parental Custody Dispositions

Name of School/Agency from which the above information is being released:

Address: _____

Signature of Parent/Guardian

Date