PARTNERS 4KIDS

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Please select from one of the following options:

☐ I hereby authorize Partners 4Kids to communicate with my child's/children's nurse/teacher at (name of school) _____ regarding pertinent health information (including physical exams, immunizations, health history, etc.).

☐ I do not want Partners 4Kids to share my child's/children's health information with his/her/their school nurses/teachers.

This consent will begin the date of this authorization and will expire within one year of "Date of Authorization," unless revoked by me in the interim. I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. All information released will be handled confidentially in compliance with the Federal Privacy Act of 1974.

X _____ X _____

Signature of Parent/Guardian

Date of Authorization

PARTNERS 4 KIDS

9000 Lockhart Gardens, Suite 16 – St. Thomas, VI 00802 – Phone: (340) 774-5437 – Fax: (888) 979-9104

Road Reef Plaza #8 - Road Town, Tortola BVI VG1110 - Phone: (284) 444-5437 - Fax: (888) 979-9104