USD 240 Parents as Teachers
223 N. Putnam Bennington, Ks 67422 785-488-3323
305 N. Minnesota Tescott, Ks 67484 785-283-4774
Fax 785-488-3326

Release of Information

In order for out PAT Educator, _____ to establish clear and continuous communication with networking agencies and to provide services in the most effective way possible, I _____, give my consent to exchange written and /or verbal information regarding _____, my child, with the following agencies or persons.

_____ Name of your child's physician:
Name:_____

Address: _____

_____ Local Health Department

_____ Local Special Education cooperative (COOP)

_____ Infant Child Development Program (ICD)

_____ Public / Private School of attendance

_____ Other Agencies:

_____

Put your **"INITALS"** next to the items below that you agree to permit. Write **"NO"** if you do not give permission. Please make sure that each item is clearly explained and that you understand each item before giving permission.

_____ I will allow photographs to be taken of my child and family and our names may be used during program activities. Our names and pictures may be used within Twin Valley Schools and may appear in PAT scrapbooks or displays.

_____ I will allow photographs to be taken of my child and family, and our names may be used for public relation new media (school website) and promotional media outside of Twin Valley Schools.

_____ I give consent for information about my child's immunizations to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

_____ _____
Parents Signature Date

_____ _____
Parent Educator Date