ATLANTA PUBLIC SCHOOLS | Student Assignment + Records
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RELEASE OF STUDENT'S MEDICAL INFORMATION

As the parent/guardian of _____ (student), I assume all responsibility for any cost of this medical recommendation. I hereby authorize release of all medical records and all of the information requested below to the Student Assignment office.

Name of Parent/Legal Guardian (Please print) _____

Signature of Parent/Guardian: _____ Date: _____

Recommendation of Physician (D.O. or M.D.), Psychiatrist (M.D.) or Clinical Psychologist (Psy.D., Ph. D)

1. Have you examined the student during the past twelve months? Yes ____ No ____

Examination Date(s): _____

Recommendation: _____

_____

_____

2. Please attach specific detailed medical reasons (physical, emotional, and/or psychological) for this recommendation.

3. Under existing court orders, only substantial medical reasons can justify exceptions to school assignments. Would you be willing to defend your recommendations should this student's application be selected for review by the court or give the school attorney a deposition in the doctor's office if ever necessary? Yes ____ No ____

Doctor's Name (please print): _____

Address: _____

Doctor's Signature_____ Date: _____