Winton School District

Date:

Student Name: DOB:

School: Grade:

☐ Frank Sparkes ☐ Sybil Crookham ☐ Winfield Elementary ☐ Winton Middle

Authorization for Exchange of Information

I hereby authorize the release/Exchange of information pertinent to the pupil named above.

_____ Educational
_____ Psychological
_____ Medical

_____ Other _____
_____ Please specify any restrictions on physical activity

From : _____
Name / Agency

_____
Address

_____
City/State/Zip

To: _____
Name & Title

Winton School District
7000 N. Center St, P.O. Box 8
Winton, CA 95388

This authorization shall remain valid for one year.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Phone: _____