Request for Teacher Input for Medical Evaluation

Student's Full Name _____

Parent/Guardian Name _____

Parent/Guardian Contact Information _____

Date Given to Staff_____ Please complete by (date) _____
(Please allow at least five school days for teachers to complete this request).

Choose One Option

_____ I will pick up the completed information from the front office at Fort Clarke. When it is ready to pick up, please email me at the email address currently on Skyward.

_____ I would like to have the completed information faxed. (parent or guardian **must provide a signed release, with fax number and name of medical provider written clearly on the release**).

Release of Student Information Between Agencies

For support, contact

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