SCHOOL DISTRICT OF INDIAN RIVER COUNTY
TEENAGE PARENT PROGRAM

CONSENT TO RELEASE/REQUEST INFORMATION

I, _____, the undersigned, authorize the
Teen Parent
Teenage Parent Program of the School District of Indian River County to release/request the following information:

MEDICAL, FINANCIAL, PSYCHOLOGICAL, SOCIAL, EDUCATIONAL,

OTHER_____

Concerning_____Date of Birth_____
(Teen Parent)

and_____ Date of Birth_____
(Teen Baby)

for the purpose of providing ***TEEN PARENT PROGRAM SERVICES***.

To/From

Indian River County Health Department, Indian River Memorial Hospital, Department of Children and Family Services, Partners in Women's Health, Healthy Start, Treasure Coast Community Health, Kindergarten Readiness Collaborative, Other Agency/Institution. _____

It is my understanding that this information is ***CONFIDENTIAL*** to those parties to/from which it is released/requested. Permission for this release/request is effective for the school year**: 2018/2019.**

*Additionally, I agree to allow the Teen Parent Program Coordinator to share **basic** information to my teachers, administrator, guidance counselor, attendance staff and school nurse regarding my condition for obtaining make up work in the event of my absence from school. (Example: Birth of baby, illness of myself or baby, duration of absences and anticipated return to school)*

Teen Parent Signature: _____

Parent/Guardian Signature: _____

Date: _____

Revised 4/18