SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
CHILD DEVELOPMENT DEPARTMENT

AUTHORIZATION AND REQUEST FOR EXCHANGE OF INFORMATION

I hereby request and authorize professional personnel of the Sacramento City Unified

School District and _____

(address) _____

the exchange of medical, psychiatric, psychological, educational, and / or social and family information in their possession pertaining to the student / family named below for the purpose of assisting in the educational planning and guidance of my child and assisting my family with social service needs.

Student name: Birth date:
Parent / Guardian Name:
Address:
City / Zip: Phone:
School of Residence:

Sending Source: (please check appropriate box(es):

____ This information is to be shared only with professional personnel

____ This information may be shared with parent and others with parent authorization.

_____ _____

Signature of Parent, Legal Guardian or Student 18 years old or over **Date**

Please forward information to:

Dr. Angélle M. Carson
Early Learning & Care Department
5735 47th Avenue, 2nd Floor
Sacramento, CA 95824