Dublin City School District

Students
5113.02 F2
Adopted 10/1/09

Authorization for the Release of Supplemental Educational Services Information

Student's Name: _____

Date of Birth: _____ School: _____

I **grant my permission** for Dublin City Schools to:

☐ RELEASE INFORMATION TO and/or ☐ RECEIVE INFORMATION FROM

the following for the purpose of Supplemental Educational Services tutoring.

Name of Person and/or Agency/Vendor: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Specific Information to be Disclosed:

☐ Grade 3-5 Ohio Reading Achievement Test Scores
☐ Achievement Test Scores
☐ Reading and/or Math Assessments included in the student record
☐ Pertinent IEP information (if applicable)
☐ Other: _____

I understand the reasons for the release of this information and have been informed of known benefits and disadvantages associated with said release. Such information will not be re-released by Dublin City Schools without my written consent. I further understand that I may refuse or withdraw in writing this consent at anytime. I give my consent freely and voluntarily.

Date of Expiration: One year from date of signature.

_____ _____
Parent/Guardian Signature Date

_____ Mother _____ Father _____ Guardian Time _____ AM/PM