CYAN CLINIC
COMPLEX YOUTH ADHD NANAIMO

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Consulting Paediatrician

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CONSENT TO RELEASE INFORMATION FROM SCHOOL

Child's name:_____ **Birthdate:**_____

To determine what services your child requires, we require your permission to contact your child's school/preschool.

Name of school/preschool:_____

Contact person:_____

Title/position:_____ **Phone:**_____

I _____, parent/legal guardian, consent for the release of any information which the school/preschool may have regarding my child's school function or development, including written or verbal reports to Dr. Francis or Michelle Surtees

Signature of parent/legal guardian:_____ Date:_____