West Lafayette Jr./Sr. High School
1105 N. Grant Street
West Lafayette, IN 47906
Phone (765) 746-0400 Fax (765) 360-8001

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

For the purpose of supporting an appropriate educational program, I give permission for a mutual exchange of information including school achievement records, attendance and tardy information, school medical information, and behavioral and discipline reports.

This consent is in effect from _____ to _____.

Name of Student _____.

Date of Birth: _____ Grade Level: _____

Classroom Teacher: _____.

This mutual exchange of information permission includes the staff and personnel at West Lafayette Jr./Sr. High School and the following person(s)

Name: _____ Relationship to child_____

Address: _____

Phone Number: _____home _____cell

Email Address: _____

Parent/ Guardian Signature of Consent: _____

Printed Name: _____

Address: _____

Phone Number:_____home_____cell

Date Signed _____

PLEASE SIGN AND RETURN TO THE SCHOOL NURSE