Authorization to Release Student Information

Cedar Falls Community School District

STUDENT NAME:_____ **DATE OF BIRTH:**____/____/_____

NAME OF PARENT OR GUARDIAN:_____

ADDRESS: _____

I, the parent or guardian of the above named student (the Student,") understand that a federal law known as the Family Education Rights and Privacy Act ("FERPA") limits the disclosure of a student's educational records. The Student has been diagnosed with a life threatening allergic condition, and I understand that information the Cedar Falls Community School District (the "District") has regarding the Student's allergic condition may be considered an "educational record" as defined by FERPA. I understand that the District's ability to communicate certain information about the Student's allergic condition to other individuals, including certain District volunteers, students, and other affiliated individuals, may be necessary to appropriately reduce the risk the Student may be exposed to an allergen, prepare individuals to notice the warning signs of an allergic reaction, and educate others about the Student's allergic condition. Therefore, I choose to authorize the District to release certain information about the Student's allergic condition to certain individuals, as more fully explained in this Authorization.

I hereby authorize the District, its directors, officers, agents, employees, and staff, to release the following educational records and all information contained therein:

> All information and records related to the Student's allergic condition, including information related to the diagnosis, treatment, and similar information, the Student's Emergency Action Plan, and any other documents or information related to the Student's allergic condition.

To the following individuals:

> District faculty, employees, staff, volunteers, and students, and all other individuals who the Student may encounter while at school or a District-sponsored event, who, in the District's reasonable judgment, may need to know information in order to appropriately reduce the risk the Student may be exposed to an allergen, prepare individuals to notice the warning signs of an allergic reaction, and educate others about the Student's allergic condition.

The purpose of this consent is to allow the District to release certain educational records, or information contained therein, whenever the District believes it is necessary or appropriate to address the Student's allergic condition.

I understand and acknowledge that: (1) I have the right not to consent to the release of the Student's education records; and (2) this consent shall remain in effect until revoked by the Student's parent or legal guardian in writing, and delivered to the District, but that any such revocation shall not affect disclosures made prior to the receipt of any the written revocation.

Signed on this ____ day of _____, 20___.

Signature:_____

Printed Name:_____

Relation to Student:_____