



DISTRICT TEAM

556 BOLESKINE ROAD, VICTORIA, BRITISH COLUMBIA V8Z 1E8

Phone (250) 475-4157 Fax (250) 475-4238

Student Information

Name:	
School:	BD:

Parent/Guardian Information

Contact Name:	Relationship:
Contact Address:	
Phone and Email:	

Your authorization is requested to exchange or submit information about your child. Please return this form to: _____

I authorize *Greater Victoria School District*, to mutually exchange information with:

- _____
- _____
- _____

Information to be released: Medical, therapy and progress reports

Purpose of the request: To plan appropriate educational programming. In order to access Special Education services, the Ministry requires school districts to have documentation to support that the student has been appropriately assessed and identified as meeting the criteria of the Special Education category.

This authorization takes effect the day that you sign it and expires one year from the date of the signature. You may revoke this authorization at any time.

- I consent to the exchange or release of the information
- I refuse consent to the exchange or release of the information

Signature

Date: