AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby authorize _____,

To release school records, medical, psychological, or any other pertinent information regarding my child, _____, to Spring Garden Community Consolidation #178.

Name of Child: _____

Date of Birth: _____ Grade: _____

Parent/Guardian Signature: _____

Date: _____

Spring Garden Elementary (Kdg-3rd):

14975 E. Bakerville Road.

Mt. Vernon, IL. 62864

Phone: (618) 244-8070 Fax: (618) 244-8071

Spring Garden Middle School (4th-8th):

511 S. Elm Street,

P.O. box 129

Ina, IL. 62846

Phone: (618) 437- 5361 Fax: (618) 437-5333

Superintendent: Mrs. Monte Jo Clark

Principal: Mrs. Tori Hartman