The College of St. Scholastica

Release of Information

Name: ________________________________
Printed

I give permission to individuals knowledgeable about my records, and that which influences my participation, in the teacher education program at the College of St. Scholastica to speak about:

Check (√) those that apply:

- □ Physical health
- □ Mental health
- □ Chemical dependency
- □ Attendance
- □ Attitude
- □ Effort
- □ Aptitude
- □ Achievement
- □ Grades
- □ Licensure issues
- □ Background Check Report and related information
- □ Other ____

I authorize my program at The College of St. Scholastica to release the report and additional required information to appropriate individuals, institutions and agencies related to clinical education. I release my program and The College of St. Scholastica from any liability as a result of such disclosure.

___________________________ ______________________
Name Relationship

___________________________ ______________________
Name Relationship

___________________________ ______________________
Name Relationship

I understand that this information is privileged and private and that it can only be discussed with my approval.

Signature:______________________________ Date: ______/_____/_____
Student's Signature