WATERFORD PUBLIC SCHOOLS

Mr. Thomas W. Giard III
Superintendent

Mr. Craig C. Powers
Assistant Superintendent

TRANSFER OF CONFIDENTIAL STUDENT INFORMATION

Date: _____

Student's Name: _____ **DOB**:_____

Name and address of transferring school: _____

_____

Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), I hereby authorize the Waterford Public Schools to obtain the following confidential records regarding my child for the purpose of enrollment in Waterford Public Schools.

(Please check all that apply)

All Records	☐
Cumulative File	☐
Pupil Personnel/Special Education	☐
Disciplinary	☐
Health/Medical*	☐
Other (please specify) _____	☐

I understand that the information to be disclosed is protected as an "education record" under FERPA, and that such information shall not be redisclosed unless permitted under FERPA. I further understand that the officers, employees, and agents of any party that receives protected information under FERPA may use such information only for purposes for which the disclosure is made.

_____ _____

Signature of Parent/Guardian Print Name of Parent/Guardian

SCHOOL INFORMATION

Please return the above authorized student records to:

❑ Waterford High School
20 Rope Ferry Road
Waterford, CT 06385
Phone: (860) 437-6956
Fax: (860) 447-7928

❑ Clark Lane Middle School
105 Clark Lane
Waterford, CT 06385
Phone: (860) 443-2837
Fax: (860) 437-6985

❑ Great Neck Elementary School
165 Great Neck Road
Waterford, CT 06385
Phone: (860) 442-2593
Fax: (860) 437-6996

❑ Oswegatchie Elementary School
470 Boston Post Road
Waterford, CT 06385
Phone: (860) 442-4331
Fax: (860) 447-6261

❑ Quaker Hill Elementary School
285 Bloomingdale Road
Quaker Hill, CT 06375
Phone: (860) 442-1095
Fax: (860) 447-6267

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***If this authorization is being used to obtain Protected Health Information from a child's physician or other covered entity under HIPAA, the following section must also be completed:**

I, the undersigned, specifically authorize _____ to disclose my child's medical information, as specified above, to my child's school, _____, at the above address for the purposes described below (i.e. health assessment for school entry, special education evaluation etc.):

_____

By signing below, I agree that a photocopy of this authorization will be valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying the physician's office in writing, but if I do, it will not have any effect on actions taken by the Physician prior to receiving such revocation.

I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my child's treatment or continued treatment with any health care provider or enrollment or eligibility for benefits with any health plan may not be conditioned upon whether or not I sign this authorization and that I may refuse to sign it.

Any information received by the school pursuant to this authorization is subject to all applicable state and federal confidentiality laws governing further use and disclosure of such information.

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_____ _____

Signature of Parent/Guardian Date

_____ _____

Print Name of Parent/Guardian Date