Exchange of Information (17 & under)

Child's Name _____ Parent's Name _____

Address _____ City _____ Zip _____

Email _____ Cell _____

Please list the professionals you wish us to contact and let us know if you would like us to observe your child at school or do any outside training.

I, the undersigned, give permission for Seven Bridges and the following professionals to share information regarding the educational or medical treatment for my child.

Name	Title	Telephone	Email Address

Parent/Guardian Signature _____ Date _____

Parent/Guardian Print Name _____