CONSENT FOR THE RELEASE OF INFORMATION

Students Name ______________ *Date of Birth* ______________ *Grade* ______________

I ______________________________ give permission to ______________________________,
(Parent or Guardian) *(Name of Students School)*

to release the below marked information of my child's records to Local Indians For Education Inc.

☐ **State Student ID#** ☐ **Attendance Records** ☐ **Report Cards**

☐ **IEP** ☐ **Behavioral Plan** ☐ **Other :**____________________.

For questions contact Local Indians For Education at PO BOX 686 Shasta Lake CA. 96019, localindiansforeducation@gmail.com, Phone-530 275-1513 or Fax-530-275-6280.

Please initial optional support services below, if needed.

______ Authorize staff to attend Student Study Team (SST) Individual Education (IEP) meetings, 504 Plan meetings.

______ Authorize staff to consult with school officials on my student's behalf.

______________________________ ______________________
Parent or Guardian Signature Date

______________________________ ______________________
LIFE Staff Signature Date