

**AUTHORIZATION TO RELEASE STUDENT TO PERSON  
OTHER THAN PARENT**

Student Name: \_\_\_\_\_

Please list any family member(s) or other authorized person(s) that may need authority to pick-up the student from school or a school related function. If not listed below, the Autism Model School will not be able to release the student into their care for any reason. You may remove or add authorized person(s) at any time by completing a new form.  
**PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY TO COMMUNICATE ANY CHANGES.**

Primary Residential Parent/Guardian: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Secondary Residential Parent/Guardian: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
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Other Authorized Person: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Other Authorized Person: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Other Authorized Person: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Other Authorized Person: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Phone Number: \_\_\_\_\_

By signing below, I give the Autism Model School permission to release my child into the care of the above named individuals. I understand that if there are any changes to this information I need to communicate these changes to the school, in writing.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date