



WELCOME TO SYLVAN!

AUTHORIZATION TO EXCHANGE INFORMATION

To make sure we provide the most effective Sylvan experience possible for your student, please share the information below.

Student Name _____ Customer Name _____

I understand that during the course of tutoring by Sylvan Learning, it may become necessary for Sylvan to consult with educators or other professionals such as physicians concerning my student. I expressly authorize and consent to a Sylvan consultation with such professionals and experts on my student's behalf. I understand that in the course of such consultation, Sylvan may receive or give information that is of a confidential nature.

I hereby authorize Sylvan to receive and give information that may be beneficial in the instruction of my student. I also authorize my student's educators, physicians, and others who may possess confidential information concerning my student to divulge and deliver that information to Sylvan. This authorization should be sufficient to authorize the delivery of such information to Sylvan. Should I, at any time, wish to retain the confidential nature of any such information, I will advise you in writing.

Please select one of the options below and sign at the bottom of the form:

YES, I have read the above and grant authorization as stated. (Please complete the information below.)

NO, I do not give permission for Sylvan to obtain or release information to any outside professional working with my student

School _____ Phone _____

Address _____

Principal _____ Counselor _____

School Website _____ Login Information _____

Additional Websites and/or Applications Used:

Student Login Information:

Teacher(s)		Subject(s)		Contact Details (email, phone)	

Scholarship: Full Partial Preferred Location: Coon Rapids Roseville Maple Grove

Customer Signature _____ Date _____



EMERGENCY RELEASE

Student Name _____ Student Age _____

Student DOB _____ Student Grade at School _____

Customer Name _____ Relationship to Student _____

Customer Address _____

Customer Email _____

Emergency Phone _____ Alternate Phone _____
☐ Mobile ☐ Work ☐ Home ☐ Mobile ☐ Work ☐ Home

Customer 2 Name _____ Relationship to Student _____

Customer 2 Address _____

Customer 2 Email _____

Emergency 2 Phone _____ Alternate Phone 2 _____
☐ Mobile ☐ Work ☐ Home ☐ Mobile ☐ Work ☐ Home

Primary Care Physician _____ Phone _____

Address _____
Street City State Zipcode

Are there any medical conditions we should be made aware of? _____

By signing this form, I am authorizing Sylvan Learning, in the event of an emergency where I cannot be contacted, to secure whatever medical care is necessary for the safety and well-being of my student. I will assume all costs incurred for emergency care.

Customer Signature _____ Date _____