



Child Medical Fax Release

I, _____, due hereby grant permission for Dr. _____ to release my child's medical information pertaining to the ODJFS prescribed medical statement to A Blessed Child Learning Academy.

Parent Information

Parent Name: _____

Address: _____

Phone: _____

Child Information

Child Name: _____ DOB: _____

Child Name: _____ DOB: _____

Child Name: _____ DOB: _____

Date Of Last Physical: _____ 20 _____

Parent Signature

Date

Please Note: The signature on this form is valid for the total of twelve (12) months from the date of signature.