Child Medical Fax Release

I, ______________________________, due hereby grant permission for Dr. ______________ to release all my child's medical information pertaining to the ODJFS prescribed medical statement to Bright Beginnings Learning Academy.

Parent Information

Parent Name: ______________________________

Address: ________________________

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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. Please return all faxes Attn: Center Director at (740) 965-6112. If you have any questions pertaining to this form, please call (740) 965-6111.