Child Medical Fax Release

I, _____, due hereby grant permission for

Dr. _____ to release all my child's medical information strictly pertaining only to the ODJFS prescribed medical statement provided to Sunny Day Academy and/or The Emilia School.

Parent Information

Parent Name: _____

Home Address: _____ City: _____ Zip: _____

Home Phone Number: (___) _____ Cell 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 a total of twelve (12) months from the date of signature. Please return all faxes attention to: Center Director at (_____) _____. If you have any additional questions, please contact us at: (_____) _____.