

## 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 Agape 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. Please return all faxes Attn: Center Director at \_\_\_\_\_. If you have any questions pertaining to this form, please call \_\_\_\_\_.