# 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 All In A Day Child Care Center.

## 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.