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 Moonlight Child Care Center.

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________

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Parent Signature

____

Date

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