



MEDICAL RECORDS RELEASE FORM

I, _____ hereby authorize my child's physician,
Dr. _____ to fax a copy of
_____ 's
shot record to AppleTree Day School for their records. My
child's D.O.B. is: _____.

Also, please sign the physician's signature line that reads
"Signature of Health Care Professional" in the middle of the
attached page to allow my child to attend this school.

If you have any questions or need to verify this transmittal you
may contact me @ _____. Thank you for your
assistance.

You may also contact AppleTree Day School for further
information.

Parent's Signature

Date