Daydreams
DAYSCHOOL

MEDICAL RECORDS RELEASE FORM

I, _____ hereby authorize my child's physician,

Dr. _____ to fax a copy of

_____'s shot record to Daydreams Dayschool 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 at _____.

Thank you for your assistance.

You may also contact Daydreams Dayschool for further information.

Parent/Guardian Signature: _____ **Date:** _____