ALCOTT SCHOOL

Consent for Medical/RX Release

I grant permission for Alcott School to contact my child's primary care physician, Dr. ______________________________ by telephone (Phone # ___________________ __________) and/or fax (fax # ________________) in order to obtain the required prescriptions/medical information necessary for my child's file.

Child's Name: __________________________ DOB: ______________________

____ ______________________
(Signature of parent/guardian) Date

____
(Relationship to child)

www.alcottschool.org

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Phone: 914-693-4443
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