ALCOTT SCHOOL

Consent for Medical/RX Release

I grant permission for the Alcott School Special Education Dept. 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)