

Release of Medical Information

I, (parent or guardian name) _____ give

(Doctor's office name) _____ permission to send medical information to:

Grandma's Kidz Childcare Center

4220 Orphanage Road

Concord, NC 28027

Phone : 704-792-1668

Fax: 704-792-1668

On the following child(ren):

Name

Date of Birth

Parent or Guardian Signature

Date