

# South Rowan Academy

417 N. Main Street  
China Grove, NC 28023  
85-LEARN (855-3276)

## PHYSICAL/MEDICAL REPORT RELEASE

To: Doctor's Office: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
From: Parent's Name: \_\_\_\_\_

C/O: South Rowan Academy of Child Development  
Return fax to: 704-855-0823

Re: Child's Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

My child(ren) (named above) is/are enrolled at South Rowan Academy of Child Development. I hereby authorize you to release to them a completed medical report/physical. This may be your own form or one that they provide to you, a Children's Medical Report.

I also authorize you to fax them a copy of my child(ren)'s shot records.

Thank you!

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Name (please print)