

If your child will need school closings, please include a copy of your child's shot records. This is a requirement. If you need us to request them from your child's doctor, please fill out this form. **NOTE: It is the parent's responsibility to make sure we receive the records. Not all doctor's offices will fax medical information.**



South Rowan
Academy of Child Development, LLC

417 N. Main Street China Grove, NC 28023
704-855-3276 | sra417@yahoo.com

Shot Record Authorization Release Form

To: Doctor's office: _____
Fax Number: _____

From: Parent's Name: _____

C/O: South Rowan Academy
Return fax: 704-855-0823

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

My child(ren) (named above) is/are enrolled in South Rowan Academy's after school program. SRA needs to have a record of my child(ren)'s immunizations. At your earliest convenience, please fax SRA a copy of my child's shot records. You have my authorization and release to do so.

Thank you!

Parent's Signature

Date

Parent's Name (please print)