BLAIR ACADEMY

RELEASE OF INFORMATION

To the Health Care Provider of ________________________________. Blair
(student's name)
Academy is an independent boarding school where my child resides during the school year. I currently reside in ______________________ and consequently the
(parent's address)
Health Center provides emergency and on-going medical care for my child.

I hereby authorize the release of any/all medical information/ records to designated representatives (RNs and MDs) of the Blair Academy Health Center for my child

___________________.
(student's name)

I also authorize North Warren Pharmacy to provide the Health Center staff with medication and information regarding my child.

Date of Birth:_____________________ (student)   Social Security #:_________________ (student)

This authorization is to remain in effect while my child is a student at Blair Academy.

_____________________   __________   ____________
Parent/ Guardian signature   Relationship   Date

Blair Academy Health Center   Fax 908-362-7885

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