MEDICAL RELEASE

I, _____ authorize the NSHAHS medical office to contact my

(parent signature)

child's physician: _____

(physician name and phone number)

and my child's dentist _____

(dentist name and phone number)

in the event of an emergency or necessity for additional information.

This medical release will remain in effect for the duration of your child's attendance at NSHAHS.

Student Name: _____

_____

(parent signature and date)