School Form Fill Out

**** Please note there is a $15 charge for school forms that must be paid before forms can be sent or picked up- PARENT REQUIRED INFORMATION AND SIGNATURES MUST BE ON FORMS in order to complete ****

Date: _____ Doctor:_____

Patient Name: _____

Date of Birth: _____

MEDS REQUESTED: _____
(if they are already on form, indicate "on form")

When form is complete, please:

1. ____ Call this person at this number to pick up:

_____
Name Number

2. ____ Fax to this number:_____
Attn:_____
By signing this, I authorize AACM to release confidential health information to the entity listed above.
X_____
Signature of Patient or Guardian Date

3. ____ Mail to this address:

_____
_____
_____