

School Form Authorization

- A \$15.00 fee per family per year must be paid at the time forms are dropped off or sent via patient portal.
- Parent or Guardian required information must be filled out and signed if requesting forms to be sent directly to school by fax.

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE: _____ PROVIDER: _____

MEDICATION REQUESTED: _____

(If medications are already on form, indicate "on form.")

WHEN FORM IS COMPLETE, PLEASE:

☐ 1.) CALL THIS PERSON: _____ PHONE NUMBER: _____ FOR PICK UP.

☐ 2.) FAX TO SCHOOL: _____ FAX NUMBER: _____.

ATTN: _____ (BY SIGNING THIS, I AUTHORIZE AACM TO RELEASE
CONFIDENTIAL HEALTH INFORMATION TO THE ENTITY LISTED ABOVE.)

X _____

Signature of Parent/Guardian

Date

☐ 3.) MAIL TO THIS ADDRESS: _____

☐ 4.) SEND BACK THROUGH PATIENT PORTAL MESSAGE.

FOR IN OFFICE USE ONLY

\$15.00 Paid on Date: _____ Admin Staff Initials: _____

Payment Type: ☐ Credit Card (last 4 digits) _____, ☐ Cash, ☐ Check, ☐ Credit on File.

Forms Completed by Nurse: _____