Medical Release of Information

Phone: 802-460-1550

Fax: 802-885-8112

Child's Name:	DOB:
I give permission for SEVCA Winds	or County Head Start to share and/or obtain
information regarding my child's medical history, including immunization records, recent	
physical records and contact information	tion with Medical provider's name
City/Town	State
*See fax/letter cover sheet for information requested.	
Thank you for your assistance,	
Parent/guardian signature	Date
Staff signature	Date
staff use only	
Date Faxed/Sent:	By:
Date Faxed/Sent:	Ву:
Date Faxed/Sent:	By:

This program is administered by Southeastern Vermont Community Action/SEVCA