

## CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, give permission for \_\_\_\_\_  
(mother, father, guardian's name) (name of health care provider)

to discuss my child's medical information, diagnosis and treatment, including medications with a representative of the YMCA's School Aged Child Care program.

**Name of Child in care** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_

Date \_\_\_\_\_

Health Care Provider's Telephone Number \_\_\_\_\_

Health Care Provider's Fax Number \_\_\_\_\_