

REQUEST FOR MEDICAL/PHYSICAL FORM COMPLETION

For Nurse Use Only
Last weight:

Patient Name: Last Name, First Name Date of Birth:

Type of Form Needing Completion: (Please check one) Day Care Form, School Medication Form, Sports Physical Form, Kindergarten Assessment, Other (specify)

Date Form Dropped off: Date Form Needed for Pick Up:

Please allow us approximately 5-7 business days for completion of form.

Please list below all medications along with dosage and frequency your child is currently taking. (Over the Counter and Prescription)

Table with 5 columns: Medication, Dosage, Frequency, Will be taking at Camp, Will Medication be taken at School. Includes checkboxes for YES/NO.

Please list a daytime phone number where you may be reached to inform you when form is completed and ready for pick up :

(area code) Phone Number

Name of Person To Pick up Form Relationship to Patient

If person picking up form is other than patient/parent, please specify full name and relationship. Please be advised that due to our policies regarding the Privacy of Patient Health Information, our staff will ask for a photo ID of person picking up form.

If unable to pick up, would you like us to mail to your home address? YES NO

Please provide us with a stamped self-addressed envelope.

Please verify your home mailing address: Street no. (P.O. Box)

City, State Zip

Due to the need for maintaining the privacy of our patient's medical information, we prefer that the form either be picked up or mailed to your home address. We do understand that extenuating circumstances may occur that would require us to fax the completed form to you. You may request our office to fax the completed form. Please complete below:

Person/Company To Whom to Fax Secured Fax Number

I give my permission to Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A./Clayton Pediatric and Adolescent Medicine to fax the requested form to the person and number specified above. I also give authorization for Jeffers, Mann and Artman Pediatric and Adolescent Medicine, P.A./Clayton Pediatric and Adolescent Medicine to release completed form to the above named person in the event the patient, parent or legal guardian is unable to pick up.

Signature of Patient, Parent, or Legal Guardian Relationship to Patient