



Frankfort-Schuyler Central School District

Authorization for School Physical

Students Name:

Students Date of Birth:

Address:

Parental/Guardian Consent

Parental/Guardian Name:

I understand that a healthcare provider from Bassett Medical Center will be visiting the school to provide physical examinations for students.

By signing below, I give permission for my child listed above, to receive an in-school physical examination conducted by a qualified provider from Bassett Medical Center.

I understand that if any concerns arise during the examination, I may be contacted for further follow-up or recommendations.

Signature of Parent/Guardian:

Date: