



SCHOOL RELEASE AUTHORIZATION

To: _____

School's Name (Please Print)

I, the undersigned, _____, parent and/or legal guardian of
_____, a student at the above designated school, hereby
authorize and give my permission for my child to ride the "Patient School Shuttle" provided by

Bret Johnson Orthodontics. I consent for my child to be released from school to ride the "Patient School Shuttle" for the purpose of receiving orthodontic services by **Bret Johnson Orthodontics.** The undersigned understands and agrees that the above child may be picked up from the school and/or returned by the "Patient School Shuttle". The undersigned assumes all responsibility for making the necessary appointments with **Bret Johnson Orthodontics'** office and for appropriately notifying school officials of the dates and times of all appointments.

This authorization shall be valid during the school year beginning in August 20__ and ending in June 20__.

Parent and/or Legal Guardian (Signature)

Patient name

Parent and/or Legal Guardian (Please Print)

Patient's DOB (Please Print)

Cell / Home Number

Grade

Emergency Contact Number

Male/Female

Date: _____

Known Allergies