New Heights Academy  Supplement Release Form

Student's Name	
Address	
City, State, Zip	
County	

Supplement Name:	
Dosage:	
Frequency:	
Time of Day:	
Additional Information	

I authorize the staff at New Heights Academy to administer the above supplement per my instructions. It is my responsibility to submit in writing any changes to my child's supplement regimen. The staff will follow this authorization only until another is submitted in writing by parent(s).

Parent Signature:	Date: MM/DD/YYYY