KIDS CENTRAL PEDIATRICS PARENTAL CONSENT FORM

Please list all persons that may have access to your child's medical information. *Example: bring child to appointments, prescription pick up, general medical information, lab results or medical emergencies.*

If their name is not on the list, they will not be allowed to have any information on the patient. Please make sure to update any changes at each appointment.

Our office will ask to make a copy of their photo i.d. when bringing your child into the office.

Child's Name: ____ Date of Birth: _____________________

Guardian Signature: ____ Date: ______________________

NAME	RELATIONSHIP TO PATIENT
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	