PARENTAL PERMISSION FOR EXAMINATION

NAME OF CHILD / PATIENT:_____ DATE OF BIRTH:_____

The following person/s has permission to bring my child to the doctor's office for a medical examination, immunizations lab test and / or treatment.

NAME:	RELATIONSHIP TO PATIENT:
_____	_____
_____	_____
_____	_____
_____	_____

THIS AUTHORIZATION IS EFFECTIVE UNTIL: _____

SIGNATURE OF PATIENT / GAURDIAN:_____ DATE:_____

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