

# PERMISSION FORM

Patient Name: \_\_\_\_\_  
\_\_\_\_\_

Please list any family members and/or friends below that have permission to bring your child to any scheduled appointments.

This person may pick up any medical records, scripts, and immunization records.

***NOTE: If someone brings your child that is not listed below, we will need a letter from the parent stating that they have permission to bring your child to their appointment.***

_____ Name	_____ Relationship to patient
_____ Name	_____ Relationship to patient
_____ Name	_____ Relationship to patient
_____ Name	_____ Relationship to patient

Thank you for your Cooperation!!!

\_\_\_\_\_  
Print Name of Parent/LegalGuardian

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date