PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission to the following adults to accompany my
(Name of Parent/Guardian)
child and authorize treatment for my child in accordance with the office policy of Springtime Pediatrics. This includes bringing the child into the office of Springtime Pediatrics, treating the child, including the administration of immunizations, administration of medication, providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective from: _____ to _____.
(effective date) (end date)

Child's Name: _____ Child's Date of Birth: _____

Child's Name: _____ Child's Date of Birth: _____

Child's Name: _____ Child's Date of Birth: _____

Child's Name: _____ Child's Date of Birth: _____

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Signature (Parent/Guardian) Date