Texoma Pediatrics

Medical Authorization for Minors

Printed Name of Child: _____

Child's Date of Birth: _____

We (I) hereby authorize the following persons to authorize medical treatment, call to request medical information, and/or sign for immunizations for the above named child:

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date: _____

1415 W. Main St. Suite 300, Durant, OK 74701/Phone: (580) 920-1980/Fax: (580) 920-9937