Kiddie Health Pediatrics, LLC
Melanie M. Garcia, M.D., F.A.A.P.

As a parent/guardian of ____,

DOB____________________, I give permission to Dr. Melanie M. Garcia to perform health assessments, physical examinations, routine screenings, evaluations and treatment of any suspected/diagnosed medical conditions.

____
Printed Name of Parent/Legal Guardian

____
Signature of Parent/Legal Guardian Date

____
Address

____
City/ State/ Zip Code

____
Telephone

____
Witness Date