

KIDDIE HEALTH PEDIATRICS

Dr. Melanie M. Garcia, MD FAAP

Patient Information

Child's Name _____

Date of Birth ____ / ____ / _____

Permission Statement

As the **parent/legal guardian** of the above-named child, I **give permission to Kiddie Health Pediatrics providers** to perform:

- Health assessment
 - Physical examination
 - Routine screening evaluation
 - Treatment of any suspected or diagnosed medical conditions
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Parent/Legal Guardian Information & Signature

Field	Signature / Information
Printed Name	_____
Signature	_____
Address	_____
Date	____ / ____ / _____