Crestwood Pediatric Associates, PC

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AUTHORIZATION FORM

Please list **all** children (under 18 years old) that come to our practice: _____

_____

I, _____, authorize the below listed person(s) to bring my child
(Parent/Guardian)
to office visits, complete paperwork, and consent to treatment and/or vaccinations in my absence:

Please list the relationship to the child.

1. Name_____ Relationship_____Ph:_____

2. Name_____ Relationship_____Ph:_____

I authorize Crestwood Pediatric to discuss medical information with the following schools and/or daycares.

School/Daycares:

1. Name_____ Ph: _____

2. Name_____ Ph: _____

This authorization is valid until I notify the office otherwise.

Name _____ **Signature:** _____

Date: _____