

Port City Pediatrics, P.L.C.

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AUTHORIZATION FOR PARENTAL CONSENT IN THE ABSENCE OF THE PARENT/GUARDIAN FOR WELL EXAMS, SICK VISITS AND IMMUNIZATIONS.

Name of child: _____

In the event that I am unable to bring my child in for well exams or sick visits, I,

_____ give permission to the following people to bring in my
(Print Parent's Name)

child for a well exam or sick visit. These people may also sign for my child to receive
his/her immunizations.

_____	_____	_____
(Name of person bringing in child)	(Phone number)	(Relationship to child)
_____	_____	_____
(Name of person bringing in child)	(Phone number)	(Relationship to child)
_____	_____	_____
(Name of person bringing in child)	(Phone number)	(Relationship to child)

I Accept. By selecting the "I Accept" button and typing your name below, you are signing this Agreement electronically.

_____	_____
(Signature of parent)	(Today's date)
_____	_____
(Signature of parent)	(Today's date)