ADDITIONAL ADULTS

Child's Name ______________________________________

Child's Date of Birth _________________________________

Parent or Guardian's Name ____________________________

I authorize the below named individual to bring my child (listed above) to the doctor's office and consent for any and all treatments on my behalf:

Name of Adult that can bring child to appointments __________________________________

Name of Adult that can bring child to appointments __________________________________

Name of Adult that can bring child to appointments __________________________________

I understand that I can revoke this authorization at any time by submitting a written request to do so with the office.

X ________________________________

Parent/Guardian e-signature