AUTHORIZATION FOR HOPE PEDIATRICS TO GIVE MEDICAL CARE IN EVENT OF PARENT'S ABSENCE

I, _____ the parent/legal guardian of _____, give my consent for the following person or persons to accompany my child to Hope Pediatrics PC and consent to the examination and/or treatment of my child during the office visit(s). I also give said person or persons my permission to sign and give consent for immunizations recommended by the physicians of Hope Pediatrics PC. In the event that I would have any objection to a particular immunization, I acknowledge that it is my responsibility to relay that information to the person or persons named below. The physicians and staff of Hope Pediatrics PC will not be responsible for any immunizations given without my permission. I also acknowledge that I will be financially responsible to pay for all immunizations given to my child whether I personally signed for them or the individual named above signed for them.

This authorization will remain in effect until revoked by me in writing.

Name of person able to bring child to appointments:

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness Date