

Kids Are Great Pediatrics

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Appointment Authorization

Patient name: _____

Date of birth: _____

I authorize the named individuals below to accompany my child, named above, to his/her appointment and make medical decisions.

Parent/Guardian: _____

Signature: _____ Date: _____

Authorized individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Start date: _____ End date: _____

*this authorization can be good for up to a year

Please sign here if this authorized individual can make decisions regarding immunizations for the above patient.

Not applicable: _____

Parent/Guardian: _____

Signature: _____ Date: _____

*we will require a copy of the parent/guardian's ID and a copy of the authorized individuals ID