PLEASANT VALLEY PEDIATRIC MEDICAL GROUP

Infants Children Adolescents

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Date: _____ Update _____ Update _____ Update _____

I _____ give permission to the person/person's listed below to seek medical care from Pleasant Valley Pediatric Medical Group for my child/children (names listed below).

_____ _____
Child's name Child's name

_____ _____
Child's name Child's name

_____ _____
Name/person allowed to seek care Name/person allowed to seek care

_____ _____
Name/person allowed to seek care Name/person allowed to seek care

___ Please check here if you do not give anyone else permission to seek medical care for your child/children.

Signature: _____