Parent/Guardian Authorization

Wareham Pediatrics
Boston Children's
Primary Care Alliance

warehampeds.com
508-295-8622

I grant permission for the person(s) listed below to bring my child in for medical visits and to make decisions regarding this child's health care.

Date: _____

Name of parent or guardian: _____

Name of child: _____

Date of birth of child: _____

I authorize the following people to accompany my child on their visit:

Person: _____

Relationship to child: _____

Person: _____

Relationship to child: _____

Person: _____

Relationship to child: _____

Person: _____

Relationship to child: _____

Date this permission begins: _____

Date this permission ends: _____

Signature of parent or guardian:

_____