PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

Authorization for Treatment and/or Immunization of Minors

In absence of parents or guardians

Today's Date:_____

Patients' Names: Date of Birth

_____
_____
_____
_____

I hereby authorize treatment of the above child(ren) and give permission for treatment during my child's preventive medical examination or sick examination. This form remains in full effect until rescinded in writting by parent/legal guardian.
The following person(s) listed below are authorized to bring my child(ren):

Name: Relationship:

_____
_____

* All persons selected to bring your child to our office must be 18 years of age or older and required to show a current photo ID.

- ☐ Pediatric Associates of Alexandria follows the recommended immunization schedule of the American Academy of Pediatrics. I give permission for the administration of the recommended vaccines.
- ☐ I hereby request no immunizations be given to my child at their examination.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name:_____

- ☐ My child is 16 years of age (or older) and has a current driver's license. I give Pediatric Associates of Alexandria authorization to treat my child for; preventive medical examination, vaccine administration, and/or sick visits.

If a provider needs to call me while my child is being seen you can contact me at:( )_____.

This form remains in full effect until rescinded in writting by parent/legal guardian.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name:_____