PEDIATRIC HEALTH CENTER OF CONYERS

Pediatric Health Center

PLEASE BE ADVISED THAT IF ANYONE OTHER THAN THE PARENTS WILL BE BRINGING YOUR CHILD ______________ ____ TO THE DOCTOR FOR EXAMINATION, IMMUNIZATIONS OR LAB TEST, THEY MUST BE LISTED BELOW THAT THEY HAVE YOUR PERMISSION TO DO SO:

Name	Relationship	Phone #

1. ____
2. ____
3. ____
4. ____

____________________________________ ______________________

SIGNATURE OF PARENT/GUARDIAN DATE

Rev 12/11

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