Caring Pediatrics Associates

37 Meridian Road
Levittown, NY 11756
Office 516-796-4433
www.caringpeds.com

AUTHORIZATION WHEN PARENT/GUARDIAN IS NOT AVAILABLE:

Patient Name: _____ DOB: _____

There may be times when I will not be present with the above named patient and I give the following persons, over the age of 18, permission to bring him or her for medical examination, treatment and/or recommended vaccines. I give permission to Caring Pediatrics and its medical staff to provide care to the named patient, as they believe necessary or advisable, in my absence. I will notify Caring Pediatrics Associates of any change in the names listed below. This document will remain active until changed, in writing by the parent(s) or guardian(s).

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

_____/_____ _____/_____

Signature Relationship Printed Name Date

_____ _____/_____

Witness Signature Witness Name Date

Notary Public _____ Date: _____

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