67 North Main Street
New City, NY 10956
Tel: 845-634-8911
Fax: 845-634-9002

I _____of _____
Parent/guardian Patient name/date of birth

Give permission to the following people to bring in my child for any sick &/or well visits including authorization to sign for immunization vaccines.

_____ _____

(Name of Adult) (Relationship)

_____ _____

(Name of Adult) (Relationship)

_____ _____

(Name of Adult) (Relationship)

I give permission for Kids Plus Pediatrics P.C. doctors and staff to leave confidential medical information on any designated contact numbers given by me including

Home _____,

Cell(Name) _____, Cell(Name)_____,

Emergency(name/phone)_____

Work_____

_____ _____

Signature of Parent/Guardian Date