PEDIATRIC AFFILIATES, P.A.

SPECIALIZING IN INFANTS, CHILDREN, & ADOLESCENT MEDICINE

Robert A. Shanik, M.D. F.A.A.P. Ira Haimowitz, D.O. F.A.A.P.

DATE: _____

TO: Pediatric Affiliates, P.A.

Patient Name: _____

Patient Date of Birth: _____

I, _____, hereby authorize the following person,
(PRINT PARENT NAME)

_____
(PRINT NAME)

to accompany and grant permission in my absence for any medical requirements, immunizations, testing, procedures and medications required therein to my child named above.

This authorization is valid from this date through my child's 18th birthday.

_____ _____
(PRINT PARENT NAME) **(SIGNATURE OF PARENT)**