

Authorization By Parent/Legal Guardian

Patient's Full Name: _____

Patient's Date of Birth: _____

The following individuals have my permission to bring my child (as named above) to Winston-Salem/Kernersville Pediatrics as well as participate in full consultation with the doctor.

1. _____

Relationship to child: _____

2. _____

Relationship to child: _____

3. _____

Relationship to child: _____

4. _____

Relationship to child: _____

5. _____

Relationship to child: _____

Parent/Legal Guardian of above named child Date