Columbia Basin PEDIATRICS
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PERMISSION TO TREAT

Date:_____

I,(Parents name)_____, am giving the following people permission to bring my child/children for an appointment at Columbia Basin Pediatrics,

Authorized Person	Relationship to child	**Authorize Immunizations? Yes	No
1. _____		☐	☐
2 ._____		☐	☐
3. _____		☐	☐
4. _____		☐	☐

The above list of names is authorized to bring the following child/children for appointments.

child _____ DOB _____

child _____ DOB _____

child _____ DOB _____

child _____ DOB _____

Additional comments:

Signature _____

Printed Name _____ Relationship to child _____

** Authorizing immunizations gives the individual(s) your permission to sign for all **required** immunizations.

* Please note that if changes need to be made to this list a new one will need to be completed.