

CACTUS CHILDREN'S CLINIC, P.C.

The following person(s) have my permission to bring _____,
Child's Name

_____, to Cactus Childrens Clinic, P.C. for medical care and treatment.
Date of Birth

The person(s) listed below can also receive medical advice concerning the above patient in person or over the phone. They will also be able to pick up necessary prescriptions (including controlled substances), x-ray and lab slips. Please note any person picking up forms, prescriptions and r lab/x-ray slips must be 18 & older and have a valid Driver License with them.

This statement will expire in 12 months from the date signed.

Name _____ Name _____
Relationship: _____ Relationship: _____
Address: _____ Address: _____
Phone #: _____ Phone #: _____

Name _____ Name _____
Relationship: _____ Relationship: _____
Address: _____ Address: _____
Phone #: _____ Phone #: _____

The above information was provided by:

Parent or legal guardian signature Date

The following person(s) is an *emergency contact only* and does not have my consent to receive medical or financial information for my child named below:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____