PEDIATRIC & ADOLESCENT MEDICAL ASSOCIATES, P.C.
117 W. LIBERTY STREET
ROME NY 13440
(315) 339-0401

AUTHORIZATION FOR MEDICAL TREATMENT AND/OR IMMUNIZATIONS

NAME OF MINOR: _____

DATE OF BIRTH: _____

I, _____, being the parent or legal guardian of the above-named minor, do hereby give my permission for:

NAME: _____

ADDRESS _____

PHONE: _____

to act on my behalf in authorizing medical and surgical care, including immunizations, for the above-named minor.

_____ _____
Signature of Parent / Guardian **Date**

Phone number where I can be contacted: _____

This authorization will remain in effect until revoked by the parent or guardian.
If the above information needs to be changed, you are liable to notify Pediatric Associates as soon as possible.