Authorization to Care for My Child

FORM 102 - R180917

I, (YOUR NAME) _____ , THE LEGAL PARENT/GUARDIAN OF THE CHILD(REN) , HEREBY AUTHORIZE THE INDIVIDUAL(S) DESIGNATED BELOW AS "AUTHORIZED INDIVIDUAL" TO BRING MY CHILD(REN) TO SALEM PEDIATRIC CLINIC FOR CARE IN MY ABSENCE. IN MY ABSENCE, AN AGENT MAY REQUEST CARE BE GIVEN AS RECOMMENDED BY MY CHILD'S PHYSICIAN AND MAY ALSO SIGN FOR ANY IMMUNIZATIONS THAT NEED TO BE GIVEN.

Signed by _____ **Date** _____

AUTHORIZED INDIVIDUALS

	Authorized Individual's Full Name	**Relationship to child(ren)**
1		
2		
3		
4		
5		
6		
7		
8		
9		

CHILDREN

	Child's Full Name	**Date of Birth**
1		
2		
3		
4		
5		
6		
7		
8		
9		

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