Siskiyou Pediatric Clinic LLP

700 SW Ramsey Ave. Suite 204
Grants Pass, OR 97527
Phone (541) 955-5683
Fax (541) 955-0983

Parental Consent

Child's name:_____ Date of Birth:_____

I, _____, (Parent/Legal Guardian) give permission for the people listed below to bring my son/daughter in for their medical appointment at Siskiyou Pediatric Clinic, LLP. It is recommended by Siskiyou Pediatric Clinic, LLP that the parent/legal guardian is present at all medical appointments; however, we understand this is not possible at all times. By signing below, you understand and agree that the person(s) listed below will be able to make medical decisions including immunizations, medical procedures, etc. on your behalf. This document will remain on file and will not change unless another consent form is filled out.

_____ _____

Parent/Legal Guardian Printed Name Date Date

_____

Parent/Legal Guardian Signature

_____

Name of Authorized Person to Bring in Patient and Relationship

_____

Name of Authorized Person to Bring in Patient and Relationship

_____

Name of Authorized Person to Bring in Patient and Relationship