



RAMSEY PEDIATRIC CENTER

Karla S Ramsey MD
Deanna Daigle, PAC
Tamara Kapplinger, PAC
Jodi McLain, PNP

I give the following individual/individuals:

Name

Relation to Patient/Patients

Name

Relation to Patient/Patients

Name

Relation to Patient/Patients

permission to bring my child to your office and make necessary medical decisions regarding treatment for my child or children:

Childs Name

Date of Birth

Childs Name

Date of Birth

Childs Name

Date of Birth

Signature of Parent or Legal Guardian

Today's Date

Please let the authorized person know that Driver's License or photo ID will be required. Authorized person must be over 21 years of age.

This form expires 12 months from date it was signed.