RAMSEY PEDIATRIC CENTER

Karla S Ramsey, MD
Kolawole Odumusi, MD
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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.

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