875 AAA Boulevard, Suite C
Newark, DE 19702
(302) 918-6400

Patient's Name: _____
Date of Birth: _____

Dear Parent or Legal Guardian,

HIPAA regulations require the following information:

Please list the name(s) of all individuals who have your permission to bring your child/children to Just Kids Pediatrics office. This authorization will allow the attending practitioner to discuss treatment options with the adult(s) you have indicated below, as well as obtain written authorization for any necessary immunizations. These adults must have knowledge of your child/children's medical history, medications and any developmental issues. Please also note who will be your child's emergency contact by checking the box to the right.

Name	**Relationship**	**Phone #**	**Emergency contact?**
_____	_____	_____	**[ ]**
_____	_____	_____	**[ ]**
_____	_____	_____	**[ ]**
_____	_____	_____	**[ ]**
_____	_____	_____	**[ ]**

I give permission for the above listed individual(s) to bring my child(ren) to Just Kids Pediatrics and to sign for any immunizations needed at the time of the visit. **I agree to update this list as necessary and to inform this office of any changes.**

_____ _____
Parent's/Guardian's Signature Date