UNIVERSITY PEDIATRIC ASSOCIATES, P.A.

INFANTS, CHILDREN, ADOLESCENTS

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Date:_____2017 thru _____2018

University Pediatric Associates,

I, _____, give _____ or
(parent's name) (person bringing in children)
_____ permission to bring and authorize

treatment for my child (ren)

1._____ 2._____

3._____ 4._____

To any one of the above named Doctors for any medical care in the office.

Thank You,

_____
(print)

_____
(sign)