CHILD HEALTH ASSOCIATES, P.C.

I _____ (name of parent/guardian) give permission for Child Health Associates, P.C. to provide all necessary medical care for my child/children

PLEASE LIST ALL CHILD/CHILDREN **LEGAL NAMES**:

M__F__ FIRST_____ MI__ LAST_____ DOB ____/____/____

M__F__ FIRST_____ MI__ LAST_____ DOB ____/____/____

M__F__ FIRST_____ MI__ LAST_____ DOB ____/____/____

M__F__ FIRST_____ MI__ LAST_____ DOB ____/____/____

M__F__ FIRST_____ MI__ LAST_____ DOB ____/____/____

M__F__ FIRST_____ MI__ LAST_____ DOB ____/____/____

PARENT AND/OR GUARDIAN (PRIMARY CONTACT)

FIRST_____ MI___ LAST_____ DOB ___/___/___

HOME ADDRESS_____ CITY_____ STATE_____ ZIP_____

CELL PHONE_____ BUSINESS PHONE_____ HOME PHONE_____

OCCUPATION_____ EMPLOYER_____ SS_____

EMAIL ADDRESS_____ PREFERRED CONTACT # CELL - HOME - BUSINESS (cirlcle one)

PARENT AND/ OR GUARDIAN (SECONDARY CONTACT)

FIRST_____ MI___ LAST_____ DOB ___/___/___

HOME ADDRESS_____ CITY_____ STATE_____ ZIP_____

CELL PHONE_____ BUSINESS PHONE_____ HOME PHONE_____

OCCUPATION_____ EMPLOYER_____ SS_____

EMAIL ADDRESS_____ PREFERRED CONTACT # CELL - HOME - BUSINESS (cirlcle one)

WITH WHOM DOES/DO THE CHILDREN RESIDE_____

PREFERRED PHARMACY NAME & LOCATION_____

****BILLING ADDRESS (IF DIFFERENT FROM ABOVE)****

NAME_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE NUMBER _____

HOW DID YOU HEAR ABOUT OUR PRACTICE:_____

EMERGENCY MEDICAL RELEASE/CONSENT

I, _____ give my permission for (list below) to seek medical care for my child/children through office visits or telephone advice. (**Someone other than the parent or guardian**)

NAME_____ **RELATIONSHIP**_____ **PHONE**_____

NAME_____ **RELATIONSHIP**_____ **PHONE**_____

NAME_____ **RELATIONSHIP**_____ **PHONE**_____

NAME_____ **RELATIONSHIP**_____ **PHONE**_____

DATE_____ **SIGNATURE**_____

NP