



CENTER FOR
pediatric
and
adolescent
 MEDICINE, PA

CPAM CHART # _____

WE IMMUNIZE
FOLLOWING THE CDC CHILDHOOD AND
ADOLESCENT IMMUNIZATION SCHEDULE

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PARENTAL AUTHORIZATION TO TREAT BY NON PARENT OR GUARDIAN

We must have permission from a patient's parent or guardian before providing medical services when the patient is accompanied by someone other than the parent or legal guardian. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information to include with your child's records.

I give my permission to the Center for Pediatric and Adolescent Medicine to allow the following person(s) to have to authorize medical care for my child:

_____ Name of Authorized Individual	_____ Relationship
_____ Name of Authorized Individual	_____ Relationship
_____ Name of Authorized Individual	_____ Relationship
_____ Name of Authorized Individual	_____ Relationship
_____ Name of Authorized Individual	_____ Relationship
_____ Name of Authorized Individual	_____ Relationship

This authorization permits the Center for Pediatric and Adolescent Medicine to accept the person(s) listed above as a parental/guardian approved person(s) to accompany the patient listed below to seek treatment at the Center for Pediatric and Adolescent Medicine.

Should the person(s) listed above or the staff of the Center for Pediatric and Adolescent Medicine need to contact me at any point during the time the patient listed below is seeking treatment, I may be reached via:

This authorization shall remain in effect until changed by the Parent or Legal Guardian above, or until the following date: ____/____/____ (Specified Date).

Required Information and Signature

_____ Name of Patient (Please Print or Type)	_____ Patient Date of Birth
_____ Signature of Patient or Patient Representative	
_____ Name of Patient Representative and Relationship to Patient (Please Print or Type)	_____ Date of Request