CENTER FOR pediatric and adolescent MEDICINE, PA

CPAM CHART # _____

WE IMMUNIZE
FOLLOWING THE CDC CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE

ELIZABETH ELLEN TILT, MD FAAP
KRISTI DESHANNON ABBOTT, MD FAAP
LISA SCHROEPFER THOMAS, MD FAAP
MEERA PATEL GALLAGHER, MD FAAP
136 GATEWAY BOULEVARD - SUITE A
MOORESVILLE, NORTH CAROLINA 28117-5608

704.799.2878 PHONE www.CPAMED.com 704.799.1627 FAX

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

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 unil 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