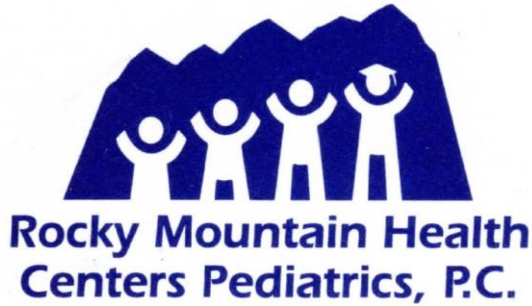

Patient Name	DOB	MRN (office use only)
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________

I, ____________________________________, give permission to the adults listed below to bring my child(ren) in for medical attention at Rocky Mountain Health Centers Pediatrics. **This includes the ability to grant permission for medical treatment (including administration of medications) and in office procedures deemed necessary by the medical staff**. I would also like to give those listed below the ability to grant permission for (please check):

Administration of immunizations: ☐ Yes ☐ No

Blood draws: ☐ Yes ☐ No

Adults granted permission to bring children to appointments:

Name (First and Last)	Relation to patient(s)
______________________________	______________________
______________________________	______________________

This consent expires: __________________________.

If no date is listed, consent will expire when a **written** request by the person listed below is received, rescinding this consent.

Signature: ____ **Date**: ____________________

Printed name of parent/guardian: ____

Relation to patient(s): ____