Advance Pediatrics PLLC
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Parent Permission Form

Patient Name:_____ Date of Birth:_____

Patient Address:_____
Street Apt#

_____
City, State Zip Code

I (we), being parent(s) or legal guardian(s), give permission to Advance Pediatrics, PLLC to consult, immunize or treat my child when they are accompanied by following adults:

Name_____ Relationship to Patient:_____Phone#_____

Name_____ Relationship to Patient:_____Phone#_____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Relationship to Patient Witness (Office Staff)