Caring Pediatrics
7645 Cita Ln, Suite 102
New Port Richey, FL 34653
Phone (727)853-2273 Fax (727) 853-2277
http://www.caringpediatrics.com

AUTHORIZATION WHEN PARENT/GUARDIAN IS NOT AVAILABLE:

Patient Name: _____ DOB:_____

There may be times when I will not be present with the above named patient and I give the following persons, over the age of 18, permission to bring him or her for medical examination, treatment and/or recommended vaccines. I give permission to Caring Pediatrics and its medical staff to provide care to the named patient as they believe necessary or advisable, in my absence. I will notify Caring Pediatrics of any change in the names listed below. This document will remain active until changed, in writing by the parent(s) or guardian(s).

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

_____/_____ _____/_____
Signature/Relationship Printed Name Date

_____ _____/_____
Witness Signature Witness Name Date