



Caring Pediatrics

4439 Rowan Rd.

New Port Richey, FL 34653

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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