WAREHAM PEDIATRICS ASSOCIATES, P.C.

53 Marion Road, Unit 1
Wareham, MA 02571
(508) 295-8622

Date:

I grant permission for the person(s) listed below to bring my child in for medical visits and to make decisions regarding this child's health care.

Name of Parent or Gaurdian:

____

Name of Child:____

Date of Birth of Child:____

I authorize the following people to accompany child to visit:

____

____

Relationship of person(s) to child:____

Date this permission begins:____

Date this permission ends:____

____
Signature of Parent of Guardian