Date:_____

Child's Name:_____

Child's Date of Birth:_____

I give the following person/persons permission to obtain care for my child at Winchester Pediatric Clinic in my absence. I also give this person/persons permission to contact Winchester Pediatric Clinic to obtain any medical advice or medical information necessary for said child.

Name:_____

Relationship to child: _____

Name:_____

Relationship to child:_____

Name:_____

Relationship to child:_____

Name:_____

Relationship to child:_____

This shall remain in effect until canceled in writing or I no longer have legal custody of said child.

Signed:_____

Relationship to Child:_____