

# Authorization for treatment of minors

I, \_\_\_\_\_, give my permission for the following adult(s):  
Print Name (Parent or Guardian)

_____	_____
Name	Relationship to child
_____	_____
Name	Relationship to child
_____	_____
Name	Relationship to child

to bring my child(ren) \_\_\_\_\_

_____	DOB
_____	DOB
_____	DOB

to Northeast Cincinnati Pediatric Assoc., Inc. for the purpose of medical examination and/or treatment. *Parent or guardian must be present for the administration of all immunizations.*

Signed: \_\_\_\_\_  
Parent or Guardian

Date: \_\_\_\_\_ (expires 1 year from this date)