Pediatrics for You
Shakti Matta, MD, MS, FAAP
6802 W Rio Grande Ave Suite 1
Kennewick WA 99336
Phone 509-572-2201 Fax 509-783-8844
www.pediatricsforyou.com

Signed Authorization for Care

Name and DOB of Child (children):

1) _____ DOB_____

2) _____DOB _____

3) _____DOB _____

4) _____DOB _____

I _____ (mother, father, or legal guardian of the above named child (ren) hereby authorize the persons named below to seek medical treatment for my child (ren).

*Include permission for any vaccinations needed. ___YES ___NO

1) _____

2) _____

3) _____

*This authorization is valid from _____to_____

Contact number(s) where Parent or Guardian can be reached: _____, _____.

Parent or Guardian Signature: _____ Date: _____ Relation to child_____

Witnessed By: _____Date:_____

(FORM IS VALID FOR 1 YEAR FROM THE DATE SIGNED.)

PFY staff use only

****

Form verified by: _____(initials)