NEW HOPE CHILDREN'S CLINIC

MEDICAL AUTHORIZATION

I, _____, being the parent and/or legal guardian of _____ (DOB: _____) do hereby give permission to the following individual(s):

Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____
Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____
Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____
Name: _____ Relationship to Child: _____
Daytime phone: _____ Other #: _____

to be contacted in an emergency, who may receive medical information about my child, may bring my child to the New Hope Children's Clinic, and authorize medical care for my children, which may include consent for procedures, vaccines or administration of medicines.

Signature of Parent (or Legal Guardian) _____

Date: _____

Witness Signature: _____