PARENTAL PERMISSION CONSENT FORM

Date: _____

I, _____, _____
(NAME) (RELATIONSHIP)

Give permission for those listed below to give consent for patient _____ Date of Birth _____ routine/standard procedures including but not limited to, immunizations, blood work, medication injections, swabs and catherizations that may be performed during routine wellness or sick visits. I also give permission for those listed below to pick up prescriptions and receive medical information concerning my child/children. The individuals listed below will have to show proper identification.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

I, _____, _____
(NAME) (RELATIONSHIP)

DO NOT give permission _____ for anyone other than myself to give consent for my child/children.

- **If any of the above information changes it will be the responsibility of the parent/guardian named above to contact our office at 985-878-5440.**

_____ _____
Father of child signature Mother of child signature