

ALTERNATE GUARDIAN DESIGNATION

I, _____, authorize the following individual(s) to accompany my child/children to Springhurst Pediatrics for their examination in my absence.

This request applies to:

Patient Name

Patient Name

Patient Name

Patient Name

Patient Name

Patient Name

I understand that a parent and/or legal guardian must accompany the child for the initial office visit and administration of all immunizations.

Authorized Signature:

Parent/Legal Guardian

Date:
