

**Parent's Authorization for Family Members or Friends
to Bring Child/Pick-up Medications**

I hereby authorize the following individuals to seek treatment, sign for
Immunizations or pick up medication/prescriptions for my child
_____ (patient's name)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand the disclosures may be made to the above person/s related to
my child's health or as needed for payment of health care services.

Also, should a medication be needed, prescriptions can be called to:

Pharmacy _____ Phone _____

Parent's signature: _____ Date _____

Daytime Phone: _____

_____ Written Acknowledgment signed or on record