

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Additional Contact Questions:**

If parents are divorced or separated or if child lives with a guardian other than a parent please fill out this section:

Who has custody?

\_\_\_\_\_  
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

\_\_\_\_\_  
\_\_\_\_\_

Emergency Contacts, other than parents. Name & Relationship:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

The following individuals have my permission to bring my children to Grace Point Pediatrics for medical office visits and treatments. This permission will remain in effect unless otherwise revoked in writing.\*\*\*:

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

\_\_\_\_\_

Signature of Parent/Legal Guardian

Date

\*\*\*Only parents, legal guardians, or individuals listed on this form may bring your child to Grace Point Pediatrics for an office visit. If you wish to send your child with an adult not listed on this form, we will require written permission from you before the visit takes place.