I, _____ give permission for person (s) listed below to seek
(PLEASE PRINT)

treatment of my child, _____ DOB _____ 20__, including any type
(PLEASE PRINT)

of procedure, office visit, (sick or well) and vaccine administration(s) at this office.

*NAME:_____

*NAME:_____

*NAME:_____

*May be revoked any time ***in writing*** to main office of Tiger Pediatrics

---

*Signature of parent/legal guardian:_____ Date:_____

---

*Valid one (1) year from date of signature above.