WATERTOWN PEDIATRICS, P.C.

North Country Medical Center · 1571 Washington Street, Suite 107 · Watertown, NY 13601
Tel: (315) 782-7330 · Fax: (315) 782-5773

Myla D. Estepa, M.D.
Joseph C. Gianfagna, M.D.
Honeylee D. Augustin, M.D.
Ashley L. Swan, MSN, FNP-C

PERMISSION FOR TREATMENT OF MINOR

(PLEASE FILL OUT COMPLETELY)

Parent's Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Name of Child: _____ Date of Birth: _____

I, _____ authorize the below mentioned person(s), to act on my behalf in my absence for the patient listed above.

Name: _____ Relationship: _____ # _____

Name: _____ Relationship: _____ # _____

Name: _____ Relationship: _____ # _____

Name: _____ Relationship: _____ # _____

DATES OF AUTHORIZATION

☐ Indefinitely OR Beginning _____ - _____ - _____ Ending _____ - _____ - _____

CHECK ALL THAT APPLY

☐ TREATMENT ☐ PRESCRIPTIONS ☐ APPOINTMENT SCHEDULING

☐ VACCINE ☐ VACCIINE ☐ RECORDS ☐ PAYMENTS

☐ OTHER _____

SIGNATURE: _____ DATE: _____

WITNESS: _____ (Must be witnessed by office staff.)

*Please remember to have above mentioned person bring photo I.D. and the patients' Insurance Card.