

Pennridge Pediatric Associates

· Pediatrics

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PERMANENT TREATMENT PERMISSION Alexandra Ellison, CRNP

Please print:			
I,NAME OF PARENT/LEGAL GUARDIA	give permission.	on to Pennridge Pediatric Associates to	
examine and treat my son or daugl	nter,		
	PATIENT NAME (S)		
	, in my absence f	or accidental injury, illness or well care,	
including immunizations when acc	companied by:		
CAREGIVER (S)		RELATIONSHIP TO PATIENT	
I hereby give permission for		RELATIONSHIP TO PATIENT	
and the immunization, and to initia	al the administration re	nt, which is information about the disease record which verifies the receipt of said to pick up forms or other paperwork for	
By signing this form you are stating	g that you understand	l and agree to all the above.	
PARENT/LEGAL GUARDIAN SIGNATURE		DATE	
WITNESS		DATE	
rev'd June 2019			

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