PEDIATRIC ASSOCIATES OF NORTH TEXAS
PERMISSION FOR CARE

My signature below indicates that I have given my permission to Pediatric Associates of North Texas and employees to vaccinate, screen for HIV (human immunodeficiency virus), provide medical attention, and treat my child or myself (for age 18 and over patient's permission given).

_____

PRINT CHILD'S NAME

_____

DATE OF BIRTH

_____

PARENT'S SIGNATURE
(OR)
PATIENT'S IF OVER 18 YRS.

_____

TODAY'S DATE