Sarasota Children's Clinic

Pediatrics & Adolescent Medicine

3920 Bee Ridge Rd Bldg A. Ste. C
Sarasota, FL 34233
941-923-3667, FAX 941-924-3246

MEDICAL AUTHORIZATION

I, _____

Do hereby authorize _____

To bring my child/children listed below to receive medical care in my absence:

Name: _____ Date of Birth: _____

_____

_____

_____

_____

This authorization also gives the above authorized person permission to sign for my child/children to receive immunizations, and any other necessary medical treatment. I understand that payment is due at the time of service; therefore, I will send payment, including copays, with the authorized individual.

Date: _____ Parent/Guardian Signature: _____

Date: _____ Witness Signature: _____