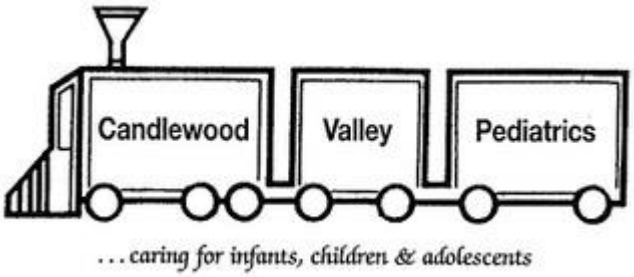

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Long-Term Permission to Treat

Parent/Guardian name _____

Person accompanying child/Relationship to child _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

☐ I give permission for the above-named person/people to accompany my child to any/all office visits until this permission has been revoked.

☐ I give permission for the doctor to administer any vaccines required, per the above-named person's/people's authorization.

☐ I give permission for the doctor to administer any necessary treatment, per the above-named person's/people's authorization.

☐ The above-named person/people may accompany my child to office visits but MAY NOT make any vaccination or treatment decisions for my child.

Parent/Guardian signature _____ Date _____