PEDIATRIC & ADOLESCENT MEDICAL ASSOCIATES, P.C.
117 W. LIBERTY STREET
ROME NY 13440
(315) 339-0401

AUTHORIZATION FOR IMMUNIZATION ADMINISTRATION

If a child requires immunizations, you must give permission.
It is the law.

NAME OF MINOR: ______________________________________

DATE OF BIRTH: ______________________________________

I, ___________________________, being the parent or legal guardian of the above-named minor, do hereby give my permission for the administration of my child's immunizations.

My child will be accompanied by:

____ ____________________
Name **Relationship**

Where I can be contacted:

Address: ______________________________

____

Phone: ______________________________

____ ______________
Parent/Guardian Signature **Date**

<u>This authorization form expires one year from date signed.</u>