Gomathi Pediatrics PLLC
67 North Main Street, 2nd Floor
New City, New York 10956
Tel: 845-634-8911
Fax: 845-634-9002

**I __________________________________ of ____________________________________________**

**Parent/guardian** **Patient name/date of birth**

**Give permission to the following people to bring in my child for any sick and/or well visits including authorization to sign for immunization vaccines.**

| ____________________________________ | ____________________________ |
|---|---|
| **(Name of Adult)** | **(Relationship)** |
| ____________________________________ | ____________________________ |
| **(Name of Adult)** | **(Relationship)** |
| ____________________________________ | ____________________________ |
| **(Name of Adult)** | **(Relationship)** |

**I give permission for Gomathi Pediatrics PLLC doctors and staff to leave confidential medical information on any designated contact numbers given by me including**

**Home:** ______________________________________

**Cell (Name):** __________________________________

**Cell (Name):** __________________________________

**Emergency (Name/Phone):** ______________________________

**Work:** _______________________________________

| ____________________________________ | ________________________ |
|---|---|
| **Signature of Parent/Guardian** | **Date** |