PARENTAL PERMISSION AND CONSENT FORM

I _____, parent and/or legal guardian of the following children:

Patient _____ Date of Birth _____

Patient _____ Date of Birth _____

Patient _____ Date of Birth _____

Patient _____ Date of Birth _____

I give permission to the following individuals listed below to seek medical treatment for the above name child/children from the office of Dr. Indira Sinha/ Children First Inc.

1 Name _____ DOB_____

Relationship to the Patient _____ SSN: _____- _____- _____(optional)

2 Name _____ DOB _____

Relationship to the Patient _____ SSN _____ - _____ - _____(optional)

3 Name _____ DOB _____

Relationship to the Patient _____ SSN _____ - _____- _____ (optional)

The above named individuals have my permission to act as my child's personal representative, in my absence, and, under the following conditions:

Individual (Please check all that apply for each person listed above)

_____ Attend all visits for medical treatment and services, including signing the necessary authorization for treatment, immunization, and receiving medical information and test result.

_____ One visit only on the following date and time _____

_____ In the event of an emergency only, and only if not available to bring my child in for treatment.

_____ Other (Please specify) _____

Patent Name _____

Parent Signature _____

Today's Date _____ Expiration Date of Consent _____