

Doctor: \_\_\_\_\_

### AUTHORIZATION FOR CAMP/SCHOOL FORMS

School Forms (\$10 per child)

Immunizations (No Charge)

Camp Forms (\$10 per child)

Other

Patient(s) Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_

Check One:  Fax  Mail  Pick-Up

Fax #: \_\_\_\_\_

**To Be Mailed To :**

Name of Recipient: \_\_\_\_\_

Street: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

*\*If no return method is checked, form(s) will be mailed to the address we have on file.*

X \_\_\_\_\_

Parent/Guardian Signature

Date

\*\*\*\*\*

### Form of Payment

*(Please include payment to expedite processing)*

Cash

Check

Credit Card

Name on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Credit Card #: \_\_\_\_\_

CVV Code: \_\_\_\_\_

Total Amount Paid: \_\_\_\_\_