

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: _____