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: ____________________