CHILDREN'S CLINIC
Washington University Clinical Associates

Parental Permission for Adolescent Care

I give the Children's Clinic permission to treat and immunize my child _____, d/o/b: _____, in the event that I am unable to accompany him/her to the office. I understand that my child will be immunized with all appropriate vaccines recommended by the American Academy of Pediatrics while here in the office. I understand if any or all of the services provided to my child are not covered by insurance, I will be personally responsible for the balance of fees.

_____
Signature of Parent/Guardian

_____
Print Parent/Guardian's Name

_____
Date