village PEDIATRICS
Malini Hebbur, M.D.
I. **Chioma Okammor, M.D.**

Medical Authorization Form

Date: _____

To Whom It May Concern:

I,_____, guardian of_____
give (Parent's Name) (Child's Name)

My permission for_____to seek medical care and make
(Caretakers Name)

medical decisions for my child as necessary on my behalf from____/____/20___to ____ /____/20___.

_____
Parent's Signature Print Name Date

_____
Witness Signature Print Name Date