

# General Consent Form

## Part I

I would like my child, \_\_\_\_\_, to receive regular medical  
*(child's name)*

care at Eastglen Pediatrics, Inc. but I may not always be able to accompany him or her. In the event my child is brought to Eastglen Pediatrics, Inc. for well care or for a sick visit by an adult other than a parent or legal guardian, I give consent for my child to receive medical care, including routine childhood immunizations.

\_\_\_\_\_  
*Witness (office staff)*

\_\_\_\_\_  
*Parent(s)'s signature*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

*Please feel free to specify certain caregivers below:*

\_\_\_\_\_

## Part II

I give consent for Eastglen Pediatrics, Inc. to release the immunization record of my child,  
\_\_\_\_\_, if requested by a preschool, daycare, school, another  
*(child's name)*  
doctor's office, or health department.

\_\_\_\_\_  
*Witness (office staff)*

\_\_\_\_\_  
*Parent(s)'s signature*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



*Please note: If you do not give your consent, you will need to sign each time your child's shot record is requested by anyone other than a parent or legal guardian.*