



Sheboygan Pediatric Associates, S.C.  
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 Sheboygan, WI 53081

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**PARENT / GUARDIAN PERMISSION – CONSENT FORM (PLEASE PRINT)**

NAME OF <b>PARENT/GUARDIAN</b> :	TODAY'S DATE:
NAME OF <b>PATIENT/CHILD</b> :	DATE OF BIRTH:
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As a parent or guardian of the *above*-named child(ren), I give permission to the individuals I have listed *below* to bring my child to health care visits, emergency visits, sign in my stead for immunizations and other services, labs, X-ray and pick-up scripts/forms that may be needed.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(Effective until signer cancels or changes consent form)*

**PLEASE PRINT:** (I give consent to the below individuals to bring my child to health care visits)

1. NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
2. NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
3. NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
4. NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
5. NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_
6. NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_