

**VALLEY PEDIATRIC MEDICAL GROUP
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**WHO CAN WE SHARE MEDICAL INFORMATION WITH ON
BEHALF OF YOUR CHILD?**

CHILD'S NAME _____ **DOB** _____

PARENT(S) NAME _____

SIBLING(S) NAME _____

GRANDPARENT(S) NAME _____

NANNY/BABYSITTER NAME _____

SCHOOL _____

(Indication of school, specifically allows us to disclose medical information regarding immunization/shots and /or medications allowed to be administered during the school day.)

OTHER _____

OTHER _____

**WHERE MAY WE LEAVE MEDICAL INFORMATION REGARDING YOUR CHILD
NAMED ABOVE?**

HOME PHONE ANSWERING MACHINE Y or N _____

Phone #

OFFICE VOICE MAIL Y or N _____

Phone #

CELL PHOHE VOICE MAIL Y or N _____

Phone #

PARENT SIGNATURE _____ **Date** _____

