East Lyme Pediatric Clinic
170 Flanders Road
Niantic, Ct 06357
(860) 739-7444

Medical Authorization Form

Patient Name: ____ Date Of Birth:______________________

Parent /Legal Guardian Name:______________________________ Phone Number:___________________

Please list the first and last name of the family members or friend that you trust to make medical decisions with your child. The member must have a driver's license or photo ID with them. **If a custody order is in place please provide our office with a copy, otherwise we legally have the right to provide both biological parents with information regarding your child.**

Please note:

Any family member or friends must have a permission letter to bring in with the child for any vaccines.

First Name: ______________________ Last Name: ______________________Relationship:__________

First Name: ______________________ Last Name: ______________________Relationship:__________

First Name: ______________________ Last Name: ______________________Relationship:__________

First Name: ______________________ Last Name: ______________________Relationship:__________

First Name: ______________________ Last Name: ______________________Relationship:__________

I have received and reviewed the notice of Medical Authorization.

Parent/legal Guardian Signature Only ______________________________________

Date signed____