RIGHT from the START PEDIATRICS

DESIGNATION OF AUTHORIZED ADULT REPRESENTATIVE(S)
and emergency contacts (other than parents)

In my absence, I hereby give permission to the following persons to bring my child or children to Right from the Start Pediatrics, SC to seek medical care.

PATIENT NAME(S) _____
DATE(S) OF BIRTH _____

Name (First and Last)	Phone	Relationship to child

I understand that care will be provided by Dr. Morra and the practice staff, including the administration of any medications and/or vaccinations deemed necessary by Dr. Morra at the time. I will make a good effort to call Dr. Morra's office with any questions I have about my child's care following any visit where I am not present. I understand that unless and until I provide written notice to the practice of any changes to the designation of authorized adult representatives, Right from the Start Pediatrics, SC, may rely on the consent provided herein.

Signature of parent / guardian or assigned representative **Relationship to child**

Print name **Date**