PERMISSION TO ACCOMPANY PATIENT

As the patient/guardian of _____Date of Birth_____

(**Patient Name)**

I give my permission for the person(s) listed below to bring the said child to their appointments. If any changes need to be made to the list, I realize it is my responsibility to request the list be revised. This list will remain in effect unless notification of change is requested by legal guardian. I also understand that the said child will not be seen if not accompanied by the parent/guardian or authorized person on this list. **I also understand the said child must be accompanied by his/her legal guardian on their initial visit.** Children being treated for ADHD must be accompanied by a parent or legal guardian at EACH visit. The person accompanying the child will be asked to present their Driver's license and proof of guardianship if required. This agreement applies to all Clinics associated with Clark Regional Physician Practices.

Our goal is to provide a safe and inviting environment. Thank you for allowing us to care for your child!

Person/Persons with permission to accompany my child:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Signature Parent/Legal Guardian_____Date_____