



Patient Name: _____ DOB: _____

I authorize MountainView Pediatrics, PC to examine and treat the above named patient, who is age 16-18, without a parent/guardian present. I understand that this authorization does not include procedures such as incision and drainage, wart removal, ingrown toenails, etc.

Print Name: _____

Relationship to child: _____

Signature: _____ Date: _____

Permission for Vaccines

I authorize MountainView Pediatrics, PC to administer vaccines WITHOUT a parent/guardian present.

Print Name: _____

Relationship to child: _____

Signature: _____ Date: _____