GRANDVILLE PEDIATRICS
2845 44TH St. SW   Ste#200
Grandville, Mi 49418
(616)538-2410
(616)538-1557

Authorization for Medical Services

Child's Name____ DOB___________________________

Child's Name____ DOB___________________________

Child's Name____ DOB___________________________

I, ____,as parent or legal guardian of the

child(ren) listed above, authorize____to bring

my child(ren) to Grandville Pediatrics for the following types of visits:

______Evaluation and treatment ______Immunizations (as recommended by the AAP)

______Lab test(s)

This Authorization is valid:

From_____________________________________To____.
Date Date

You may reach me at the following phone number_____________________________________.

Preferred Pharmacy____.
Name of Pharmacy Location of Pharmacy

Signed:____Date__________________________