Pediatric Care Center

4504 Diamond Ruby, Suite 3
Christiansted, St. Croix
U.S. Virgin Islands 00820
Telephone: 340-719-0681
Facsimile: 340-719-9023

Written Authorization to obtain Immunization

We, the parents\legal guardian(s) of _____
(Name of minor child)

_____
Name of Parent(s)/Guardian(s)

Provide consent to Pediatric Care Center for immunization of our\my minor child\children.

I do hereby request and authorize the medical staff to perform necessary medical services including immunization for the child\children named above.

I\we understand that this written authorization may be withdrawn at any time by providing notice in writing. The notice of withdrawal must be given to the person authorized above and to any health care provider who was given a copy of this written authorization.

This Consent is given this _____day of _____, 2019

Signed: _____ *Date:* _____
Parent(s)\Legal Guardian(s)

Witnessed: _____*Date:*_____

"With you every little step of the way"