IWONA MIENKO, MD FAAP

I give permission to the office of Iwona Mienko, M.D. to treat and/or immunize my child in the event that I am unable to accompany him or her to the office. I understand that in all situations the doctor prefers to have a parent present to obtain a medical history and to give permission for treatment or vaccinations. By sending my child with a caregiver or by sending my adolescent child alone, I am giving advance consent to any medical procedure the physician deems necessary.

Persons other than a parent or legal guardian authorized to accompany my child to an appointment include:

Name__________________________________Relationship:__________________Phone #___________

Name__________________________________Relationship:__________________Phone #___________

Name__________________________________Relationship:__________________Phone #___________

Child's Name(s): ____ DOB: ________________________

Child's Name(s): ____ DOB: ________________________

Child's Name(s): ____ DOB: ________________________

Print Name__________________________________Phone number_______________________________

Signature of Parent/Guardian:________________________________Date _______________________