Nancy Aria, M.D.
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I give permission for my child to be medically and evaluated by Dr. Nancy Aria in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation. I accept responsibility for the physician's charges and laboratory fees. If there are any services that you do not consent to in your absence, please list:

_____
_____
_____

My child will be accompanied by:
___ himself/herself
___ babysitter (name) _____
___ other (name and relationship) _____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____ _____
Child's name, Date of Birth Date

_____ _____
Parent/ Guardian Signature Parent/ Guardian Name

_____
Phone number where parent/ guardian can be reached