



REQUEST FOR FORM COMPLETION

PATIENT/GUARDIAN:

I REQUEST THE ATTACHED FORMS BE COMPLETED FOR THE FOLLOWING PATIENT(S). I UNDERSTAND THAT THERE WILL BE A FEE OF **\$20 PER FORM OR \$35 FOR RUSH FORM**. I FURTHER UNDERSTAND THAT PAYMENT IS REQUIRED WHEN DROPPING OFF THE FORM IN ORDER FOR THE FORM TO BE COMPLETED. THE PRACTICE DOES NOT BILL LATER FOR FORMS. I UNDERSTAND THAT THE POLICY OF CHILDREN FIRST PEDIATRICS IS TO COMPLETE MOST FORM WITHIN 5 DAYS, BUT BUSIER TIMES OF THE YEAR IT MAY TAKE LONGER AND I WILL BE INFORMED OF THE TIME TO COMPLETE.

NOTE: PATIENT(S) MUST HAVE HAD A PHYSICAL EXAM WITHIN A YEAR FOR THE FORM TO BE COMPLETED.

IT IS IMPORTANT TO FILL OUT THE FOLLOWING INFORMATION COMPLETELY SO THAT YOUR REQUEST DOES NOT INCUR DELAYS.

PATIENT NAME	DOB	ALLERGIES	CURRENT MEDICATION(S) NAME & DOSAGE	MEDICATION(S) TO BE TAKEN AT SCHOOL, DAYCARE OR CAMP
1.				
2.				
3.				

ALL FORMS WILL BE PUBLISHED TO THE PATIENT PORTAL WHEN DONE. WE NO LONGER MAIL HOME AND NO NEED FOR YOU TO MAKE A TRIP TO THE OFFICE!

DURING THE DAY, I MAY BE REACHED AT: _____ - _____ - _____ IF THERE ARE ANY QUESTION WHEN COMPLETING FORMS.

SIGNATURE OF REQUESTOR

RELATIONSHIP TO PATIENT

DATE

OFFICE USE ONLY

FORM OF PAYMENT _____ AMOUNT PAID \$ _____ DATE OF PAYMENT _____

FORMS COMPLETED BY (NURSE INITIAL) _____ DATE COMPLETED _____

COMMENTS: _____