GLENDALE AREA MEDICAL CENTER
850 Main Street
PO Box 375
Coalport, PA 16627
(814) 672-5141

To whom it may concern:

I, ________________________________ give permission for
(Parent or guardian)

__________________________________ to bring my child,

__________________________________ for immunizations or any
(Child's name)

necessary medical care at the Glendale Area Medical Center.

Parent Signature _________________________________

Date ____

Witness _______________________________________