Children's MINNESOTA

FORM COMPLETION REQUEST

As a reminder your child must be up-to-date on physical exams to complete any forms. Please complete patient/parent/guardian section of forms prior to sending to the clinic for completion. If sections are not complete, the form may not be able to be completed by the provider.

I give Children's Minnesota permission *to complete form(s) and send information as indicated below. This consent will expire only when revoked in writing. If child is 18 years of a*ge or older they must sign this form.

1. PATIENT INFORMATION

Patient Name: _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

2. INFORMATION REQUESTED

Please specify type of form:

- ☐ **Sports Qualifying Form**
- ☐ **School form**
- ☐ **Daycare**
- ☐ **Camp**
- ☐ **Medication administration form**
- ☐ **Other**
  _____
  _____
  _____
  _____

Do you also need?:

☐ **Immunization Record** ☐ **Asthma Action Plan** ☐ **Allergy Action Plan** ☐ **Seizure Action Plan**

3. HOW WOULD YOU LIKE INFORMATION DELIVERED

☐ **Will pick up completed form at office; notify me at # (_____) - _____ - _____**

☐ **Fax**
Facility Name: _____

ATTN: _____

Fax number: _____

☐ **Mail**
Facility Name: _____

ATTN: _____

Address: _____
_____
_____

☐ **Verbal**. I give Children's Minnesota permission to speak about the patient information listed above in section 2 with the individuals listed above in section 3.

4. SIGNATURE

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

* R O I *

Completed by date: _____

Completed by initials: _____

PLACE PATIENT LABEL HERE