WEST HILLS CHILDREN'S MEDICAL GROUP

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7301 Medical Center Dr., Suite 300
West Hills, CA 91307

I give permission for the following people to bring my child(ren) in to West Hills Children's Medical Group for treatment/physicals.

Child(ren) Name: DOB:

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People allowed to bring my child(ren) to West Hills Children's Medical Group:

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Parent Signature:_____ Date:_____