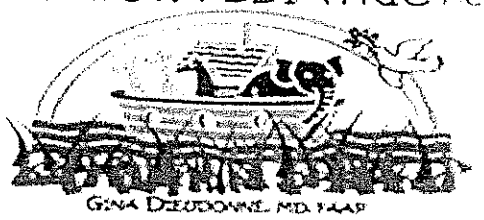
RAINBOW PEDIATRIC P.C.



I, _____, do hereby give Rainbow Pediatric permission to evaluate, diagnose and treat my son/daughter, _____, in my absence. I give permission to _____my _____ (relationship to parent) to accompany my child if I am not available to be there.

_____ _____

Signature Date

1636 Main Street, Humboldt, TN 38343
Phone: 731-784-7833 Fax: 731-784-7856