



**Preferred Pediatrics**

824 W. Frontier Lane • Olathe, Kansas 66061 • (913) 764-7060

Stuart G. Shanker, M.D., FAAP  
F. Lance Miller, M.D., FAAP  
Amy L. Voelker, M.D., FAAP  
Allison S. Hettinger, M.D., FAAP

I AUTHORIZE: (SCHOOL'S NAME)

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TO FILL OUT ADD/ADHD FORMS ON: (PATIENT NAME & DATE OF BIRTH)

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\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

DATE \_\_\_\_\_

