FAIRPORT
PEDIATRICS, LLP

OMT Consent Form

Patient Name: _____ DOB: _____

Current practice name: _____

Current PCP: _____

Medical conditions: _____

Surgical history: _____

Allergies: _____

Medications/supplements/ vitamins: _____

Indication for OMT (please circle one):

Asthma	Headaches	Musculoskeletal pain
Constipation	Plagiocephaly	Other (please describe):
Sinus infections	Torticollis	
Ear infections	Feeding concerns	

At Fairport Pediatrics, we are committed to providing a safe and healthy environment for all of our patients. In line with the recommendations of the American Academy of Pediatrics (AAP), we require that all patients be up to date on all required childhood vaccinations as part of our standard of care.

Signature required on the reverse side of this form

FAIRPORT PEDIATRICS, LLP

By signing below, I acknowledge and agree to the following:

I understand that Fairport Pediatrics requires all patients to be up to date on all required vaccinations.

I confirm that my child is currently up to date on all required vaccines for their age, as recommended by the CDC and AAP.

I understand that failure to maintain an up-to-date vaccination status may affect my child's ability to remain a patient at this practice.

I understand that Dr. Domalski is providing a consultation service for OMT.

This service does not include prescribing medications, ordering imaging or laboratory evaluation, or referrals.

Name of Parent/ Guardian: _____

Signature of guardian: _____ Date: _____