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## FORM COMPLETION REQUEST

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**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Type of form requested:**

- |   |   |
|---|---|
| <input type="checkbox"/> Sports Qualifying Form         | <input type="checkbox"/> Special Olympics             |
| <input type="checkbox"/> School Form                    | <input type="checkbox"/> Head Start/CAP/PICA          |
| <input type="checkbox"/> Daycare                        | <input type="checkbox"/> Therapeutic Horseback Riding |
| <input type="checkbox"/> Camp                           | <input type="checkbox"/> Other, specify:              |
| <input type="checkbox"/> Medication Administration Form |   |

Has your child tested positive for COVID-19 in the last six months?      Yes      No

Do you also need:

- Immunization Record?       Asthma Action Plan?       Allergy Action Plan?

For return of forms, please select one of the options below and complete the information:

**FAX to:**      Number: \_\_\_\_\_      Attention: \_\_\_\_\_

**Mail to:**      Attention: \_\_\_\_\_      Address: \_\_\_\_\_

**Pick Up:**      MP Office: \_\_\_\_\_      Notify At: (      ) \_\_\_\_\_

**Encrypted E-Mail:**      Address: \_\_\_\_\_

Please note: Your child must be up-to-date on physical exams in order to complete forms. Forms may take up to 72 hours to complete.

I give permission for Metropolitan Pediatrics, PA to complete form(s) as indicated. (If the child is 18 years old or older, their signature is required.)

**Printed Name of Parent/Guardian:** \_\_\_\_\_

**Contact Number For Questions:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

14050 Nicollet Avenue, Suite 300  
Burnsville, MN 55337  
Telephone: (952) 435-2450  
FAX: (952) 892-0217

6517 Drew Avenue South  
Edina, MN 55435  
Telephone: (952) 920-9191  
FAX: (952) 920-0232

1515 St. Francis Avenue, Suite 100  
Shakopee, MN 55379  
Telephone: (952) 445-6700  
FAX: (952) 445-3527