Authorization to Treat

Parents or Guardians:

In the event you are unable to bring your child for care at Premier Pediatrics; please list who may bring your child for treatment. (i.e. stepparents, grandparents, babysitters, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This signed consent will allow Premier Pediatrics to provide the appropriately needed care for your child in the event of illness or an accident.

Please list **ALL** children who may be accompanied by the above mentioned individuals.

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

□ No other individuals may bring my child(ren) for care.

This consent shall expire one year from the date the form was completed.

_____

PRINT PARENT/GUARDIAN NAME

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

PREMIER PEDIATRICS
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