PEDIATRIC ASSOCIATES OF PLYMOUTH, INC.

PEDIATRIC AND ADOLESCENT MEDICINE

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HOURS BY APPOINTMENT ONLY

Walton Campus
3031 Walton Road
Building C, Suite 101
Plymouth Meeting, PA 19462
Phone 610-825-3500 / Fax 610-825-8502

50 West Third Avenue, Suite 400
Collegeville, PA 19426
Phone 610-489-2229 / Fax 610-489-4788

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _____, the parent and legal guardian of _____,
(name of parent)
_____,
_____,
_____, } List names

hereby authorize _____ _____
(name of person bringing child to the office) (name of person bringing child to the office)

_____ _____
(name of person bringing child to the office) (name of person bringing child to the office)

to accompany my above-named child to office visits with Pediatric Associates of Plymouth, Inc.

and consent to the examination and/or treatment of my child during the office visits. This authorization includes necessary bloodwork as well as the administration of any recommended immunizations.

This authorization:

- ❑ is effective only on _____.
- ❑ is effective from _____ to _____.
- ❑ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above named physician.

_____ _____
(Signature of Witness) (Signature of Parent/Guardian)

_____ _____
(Date) (Date)