Pediatric Associates OF PLYMOUTH

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Building a Healthier Future for Your Child

AUTHORIZATION TO TREAT MINOR PATIENT IN ABSENCE OF PARENT/GUARDIAN

I, _____, the parent and legal guardian of

(list child/children first and last names)_____

_____

hereby authorize the following adults(over 18):

_____ _____
Name Relationship to child/children

_____ _____
Name Relationship to child/children

_____ _____
Name Relationship to child/children

to accompany my above-named child/children to office visits with Pediatric Associates of Plymouth and consent to the examination and/or treatment of my child/children 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.

_____ _____
Signature of Witness Signature of Parent/Guardian

Date: _____ Date: _____

Forms & Protocols/lgs/February 2016 File and/or scan into patients' records ____

OFFICES

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