Parental Consent for Medical Treatment

Child's Information

Child's Name	Date of Birth
Home Address	Home Phone Number
City, State, Zip Code	
Parental Contact	Phone Number

Caregiver Information

Caregiver's Name	Phone Number

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, etc.), for the above named child, which may be required during my absence.

If circumstances permit, please attempt to contact me at the following telephone number:

___________________.

This consent serves as permission for treatment by Southdale Pediatric Associates, Ltd. Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until (select one):

a) ___________________ (Month, Day, Year) b) unless earlier revoked by me.

Signature

____

Parent/Guardian (circle one) Date

____

Witness Date