BAY AREA PEDIATRICS

Parent/Guardian Consent for Medical Treatment

Child's Information

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Child's Name _____ Date of Birth _____

Parent/Guardian (circle one) _____ Phone Number _____

Caregiver's Information

1) Caregiver's Name _____ Phone Number _____

2) Caregiver's Name _____ Phone Number _____

3) Caregiver's Name _____ Phone Number _____

The above named caregiver(s) shall be authorized to consent for all medical treatment, medical procedures and/or diagnostic testing, etc., for the above named child, which may be required during my absence.

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

_____

This consent serves as permission for treatment by Bay Area Pediatrics, LLC. **NOTE: Consents are NOT required in emergency situations**. This authorization shall be effective until (select one of the following:)

a) _____ (month, day, year) b) unless earlier revoked by me.

Signature

Parent/Guardian (circle one) _____ Date _____

Witness _____ Date _____