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

_____ _____
Child's Name Date of Birth

Caregiver's Information (OTHER THAN PARENT/GUARDIAN)

_____ _____ _____
Caregiver's Name Relationship to Patient Phone Number

_____ _____ _____
Caregiver's Name Relationship to Patient Phone Number

_____ _____ _____
Caregiver's Name Relationship to Patient Phone Number

1. I give permission for the above-named caregiver(s) to authorize/consent for all medical treatment, all medical procedures, all diagnostic testing, all immunizations, all screenings, etc., for the above-named child(ren), which may be required during my absence, while being seen at Bay Area Pediatrics.

   Consents are NOT required in emergency situations.

   This authorization shall remain in effect until: (circle one of the following)

   A) _____ OR B) unless revoked by me
   month, day, year

2. I do not give permission for the above-named patient(s) to be seen in the office in the absence of a parent/guardian, as listed below, other than in an emergency. _____
   Initial of parent/guardian

Signature

_____ _____ _____
Parent/Guardian (circle one) Relationship to Patient Date

_____ _____ _____
Parent/Guardian (circle one) Relationship to Patient Date