



Integrative Pediatrics, LLC
Safe passage in a changing world.

Authorization for Consent to Treatment

I, _____ certify that I am the Parent/Legal Guardian of the following child(ren):

Names and D.O.B.

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As Such, I authorize: _____
Full Name Phone #

Who is 18 years of age or older. To consent to any normal and /or emergency medical and/or surgical treatment of the above child (ren) which the above named person deems advisable if I cannot reasonable be located through the information set out below when the child (ren) are brought in for treatment.

The above authorization will be effective as of _____, and will expire after (6) six months, or on _____. Whichever occurs first.

Printed Full Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date

Witnessed by: _____

Phone Number of Parent or Legal Guardian: _____

Address: _____

Work Number of Parent or Legal Guardian: _____

Employer: _____