Integrative Pediatrics

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):

_____

Name and Date of Birth

_____

Name and Date of Birth

As Such, I authorize: _____

Full Name Phone #

This person is 18 years of age or older. The person stated above is authorized 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 be reasonably located through the information set out below when the child (ren) receives treatment.

The above authorization will be effective as of _____, and will expire after (2) two years, or on _____, whichever occurs first.

_____

Printed Full Name of Parent or Legal Guardian

_____

Signature of Parent or Legal Guardian Date

Witnessed by: _____

Information of Parent or Legal Guardian

Phone number: _____

Work number : _____

Address:_____

Employer: _____