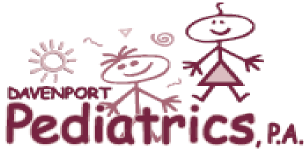

DAVENPORT PEDIATRICS

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

MEDICAL TREATMENT AUTHORIZATION AND CONSENT

This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult(s) to arrange for routine or emergency medical care for the child when either the parents or legal guardians are unable to accompany the child and approve or consent to the child's medical care.

This is extremely important because medical care cannot be provided to the child without the approval or consent by either the child's parents or legal guardians, unless there is written consent authorizing another adult to approve or consent to the child's medical care.

DATE: ______________________
MM / DD / YYYY

I, ___________________________________, parent or legal guardian of ___________________________________,
(Name of Parent or Legal Guardian) (Name of Child)

hereby give authorization to the following person(s) to accompany my child and to approve or consent to any medical care or treatment to be provided by DAVENPORT PEDIATRICS, P.A., its physicians and support staff to my child.

	Name	Relationship to Child
1.	___________________________	___________________________
2.	___________________________	___________________________
3.	___________________________	___________________________
4.	___________________________	___________________________
5.	___________________________	___________________________

____
(Signature of Parent/ Guardian)

Persons on the above list must have proper identification (ID) to have the patient treated.