Parent/Legal Guardian Authorization for Medical Care for Child

Name of Child: ________________________________

Date of Birth: _________________________________

I (We) ______________________________
Parent/Legal Guardian

Grant _______________________________
Person Accompanying Child

permission to seek medical care and consent to treatment as deemed necessary to the above named dependant in my absence. The care will be given at the office of ____Jane Pardieck, M.D._________.
Name of Physician and/or Practice

Parent/Legal Guardian Signature: ___________________________

Date: ____________________________