# AUTHORIZATION FOR TREATMENT
## HOSPITAL DRIVE PEDIATRICS

(If someone other than a parent or legal guardian will bring child in.)

ALL CAREGIVERS MUST BE AT LEAST 18 YEARS OLD

**Patient's Name** _____ □M □F DOB _____

Do you have other children who come here? Names & birth dates: _____

_____

**Authorized Caregiver's Name**_____ Relationship_____

Home ( )_____ Work ( )_____ Cell ( )_____

Street Address □Same _____Apt#_____

City_____ State_____ Zip_____

*I authorize this person to bring my child in for appointments and to consent for any treatment recommended for my child. I understand that treatment might include medication, radiologic procedures, vaccination, or other medical procedures.*

**Authorized Caregiver's Name**_____ Relationship_____

Home ( )_____ Work ( )_____ Cell ( )_____

Street Address □Same _____Apt#_____

City_____ State_____ Zip_____

*I authorize this person to bring my child in for treatment without me. I understand that treatment might include medication, radiologic procedures, vaccination, or other medical procedures.*

*I □will □will not be available by phone.* ( )_____

_____ Date_____

Parent's Signature

_____ Valid until _____

Parent's Name