***Children's Choice Pediatrics***

**Parental Consent for Medical Treatment/ Assignment of caregiver**

 **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child's Information**

Child's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

 **Caregiver's Information**

1- Caregiver's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2- Caregiver's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3- Caregiver's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above named caregiver is acting *in loco parentis*and shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, vaccines, diagnostic tests, physical exam, etc.), for the above named child, which may be required during my absence. This consent serves as permission for treatment at the offices of Children's Choice Pediatrics. Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence.

This authorization shall be effective until (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ unless earlier revoked in writing to Children's Choice Pediatrics, by me.

Parent/Legal Guardian's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signatures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Legal Guardian