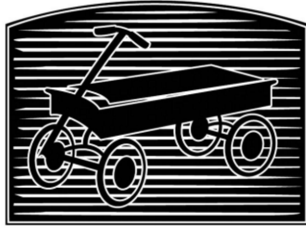

Permission to Treat

Date ___________________________

I, ____, the parent of…

Patient's Name:_______________________________________ DOB:_____________________________

Patient's Name:_______________________________________ DOB:_____________________________

Patient's Name:_______________________________________ DOB:_____________________________

Patient's Name:_______________________________________ DOB:_____________________________

…do hereby give permission to the following listed person(s) to obtain medical treatment for the above referenced child(ren) with a provider of Hometown Pediatrics, P.A. This person(s) has my permission for medical decision-making included but not limited to administration of medications or vaccines, diagnostic or therapeutic procedures, and/or admission to the hospital, etc.

Name:	Relationship:
____	_______________________________________
____	_______________________________________
____	_______________________________________

This consent shall remain effective until revoked in writing and received by Hometown Pediatrics, P.A.

or until ____

In case of emergency, the parents may be reached at: ____

____	_______________________________________
Parent's Name (Printed)	Parent's Signature

Rev 04/18