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### MEDICAL CARE AUTHORIZATION FORM

Please review the following Authorization for Treatment. Complete the information if you would like to grant prior permission for medical treatment for your child/ren in the event of your absence.

Name of Child/ren

Date of Birth

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please place your initials next to each line as appropriate**

I (We), being the parent(s) or guardian(s) entitled to the care, custody and control of the above named minor(s) do hereby authorize **(print name and contact number of the adult who will be caring for the child)**.

Name: \_\_\_\_\_ phone number: \_\_\_\_\_ to

\_\_\_\_ Seek appropriate medical treatment or attention on behalf of the child/ren as may be required by the circumstances including the scheduling of appointments.

\_\_\_\_ Sign for medical treatment (including preventative care, sick child care, immunizations, urgent and emergent care) by Stapleton Pediatrics and its personnel for the above named child/ren.  
**Cross out and initial any items you do not consent to.**

\_\_\_\_ Receive financial information

\_\_\_\_ Receive health care information via phone

I agree to keep Stapleton Pediatrics informed of changes in phone numbers, contact info and any custodial changes related to my child/ren listed above.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

This authorization is in effect for 1 year from date listed above unless otherwise specified below:

From: \_\_\_\_\_ Until: \_\_\_\_\_