



Parental Consent for Medical Treatment

Child's Information

Child's Name

Date of Birth

Home Address

Home Phone Number

City, State, Zip

Parent / Legal Guardian's Name

Phone Number (Cell / Work)

Parent / Legal Guardian's Name

Phone Number (Cell / Work)

Caregiver's Information

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, diagnostic tests, etc.), for the above named child, which may be required during my absence.

This consent serves as permission for treatment at **PTARMIGAN PEDIATRICS, LLC**. 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

_____ unless earlier revoked in writing to Ptarmigan Pediatrics, LLC, by me.
Month / Day / Year

Signatures

Parent / Legal Guardian (circle one)

Date

Parent / Legal Guardian (circle one)

Date

Witness

Date