Permission to Treat

I (We) _____

Print name(s) of Legal guardian(s)

Authorize **PEDIATRIC CARE OF FOUR CORNERS** and its personnel to deliver medical services to my child(ren):

_____

Print child's name and date of birth

_____

Print child's name and date of birth

_____

Print child's name and date of birth

_____

Print child's name and date of birth

_____

Print child's name and date of birth

I (We)

_____

Authorize the following people to bring my child in for treatment:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Signature of Legal Guardian Date

_____

Relationship to patient