



PARENTAL AUTHORIZATION FORM For Another Adult to Take a Child for Medical Treatment

I give permission for the following to authorize medical treatment for my child in the event that I am not available.

Child's Name _____ Date of Birth _____

List two people on the lines below other than a parent/guardian.

Name _____ Relation to Child _____

Name _____ Relation to Child _____

Parent's Name _____ Date _____

Parent's Signature _____ Telephone _____

NOTE: If, at any time, a person listed above no longer has your permission to authorize treatment or to take your child to Ellenton Pediatrics, it is your responsibility to inform us with a letter stating that you are withdrawing your permission.