

## Parent/Guardian Consent for Medical Treatment

Name(s) of Child(ren):

---

---

---

---

\_\_\_\_\_  
PARENT/GUARDIAN NAME

\_\_\_\_\_  
PHONE

\_\_\_\_\_  
CAREGIVER NAME

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
CAREGIVER NAME

\_\_\_\_\_  
RELATIONSHIP

The above named person(s) shall be authorized to bring my child(ren) to TLC Pediatric & Adolescent Medicine, P.A. for medical treatment in my absence. This consent includes:

- ALL MEDICAL TREATMENT (INCLUDING INJECTIONS)
- OFFICE VISIT ONLY

I agree to be financially responsible for all services rendered in my absence.

This authorization is effective until specifically cancelled by me.

\*\*\*\*\*The "Caregivers" must bring proper identification to the office.\*\*\*\*\*

\_\_\_\_\_  
SIGNATURE: PARENT/GUARDIAN

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

