



Pediatric Healthcare Associates, P.A.

Authorization for Medical Care to Minors

I _____ the parent or legal guardian of the minor(s) listed below:

_____ DOB _____

_____ DOB _____

_____ DOB _____

Do hereby authorize medical treatment by Pediatric Healthcare Associates.

Name of adult person(s) who can bring child in for medical treatment

Telephone number(s) where the parent or guardian can be reached.

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Parent signature & relationship to minor

Date