



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,
P.A..

Name of the adult person(s) authorized to bring minor child in for medical
treatment.

_____ Relation _____

_____ Relation _____

_____ Relation _____

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

Home: _____ Cell: _____ Work: _____

_____ Date _____

Parent Signature & relation to minor child

