Interlachen Pediatrics
Consent for Treatment

I, _____ , as parent/ legal guardian, give authorization for _____ , to bring my child(ren) to Interlachen Pediatrics. This person has permission to discuss my child's medical conditions and make decisions concerning treatment on my behalf.

_____	_____
Child's Name	DOB
_____	_____
Child's Name	DOB
_____	_____
Child's Name	DOB
_____	_____
Child's Name	DOB
_____	_____
Parent/Legal Guardian	Date

This authorization will expire two (2) years from the date listed above and/or if revoked.

Sworn to and subscribed to me this _____ day of _____, 20 ____ .

- o Personally known
- o Identification produced _____

Notary: _____

Seminole County, Florida

(Seal)