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 Signature	Date

This authorization will remain in effect from the date signed until the patient(s) reach legal age (18) and/or if revoked.

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

- Personally known
- Identification produced _____

Notary: _____

(Seal)