AUTHORIZATION FOR TREATMENT OF CHILD IN ABSENCE OF PARENT/LEGAL GUARDIAN

Child's Name: _____ **Date of Birth:** _____

Authorization Given To:

Name: _____ **Relationship to Child:** _____

Name: _____ **Relationship to Child:** _____

Name: _____ **Relationship to Child:** _____

Name: _____ **Relationship to Child:** _____

I, the undersigned parent or legal guardian of the above named child, give permission to the adults(s) named above to act on my behalf to obtain medical care and treatment for my child as deemed advisable by the providers at Cornerstone Pediatrics.

Parent/Legal Guardian _____ **Date:** _____