Hometown
PEDIATRICS

Permission to Treat

Date:_____

I, _____, the parent of:

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Give permission to the following listed person(s) to obtain medical treatment for the above referenced child(ren) with a provider of Hometown Pediatrics. This person(s) has my permission for medical decision making including but not limited to: administration of medication or vaccines, diagnostic or therapeutic procedures, and/or admission to the hospital, etc.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

This consent shall remain effective until revoked in writing and received by Hometown Pediatrics or until_____.

In case of an emergency, the parent(s) may be reached at: _____

_____ _____

Parent's Name (Printed) Parent's Signature

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