PONDEROSA PEDIATRICS

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PATIENT'S EMERGENCY CONSENT FORM

Patient Name:_____Patient DOB: _____

CONSENT: This consent authorizes the listed people below to bring your child for their appointment on your behalf. As well as, be able to give consent for all medical and/or surgical treatment that may be required for your child during your absence. It also authorizes the named individuals to make, change, and/or cancel medical appointments, and pick up forms and prescriptions for the patient.

☐ **I hereby authorize the following person/s to give consent:**

Name:_____DOB:_____

Phone:_____Relationship to Patient: _____

Name:_____DOB:_____

Phone:_____Relationship to Patient: _____

☐ **I hereby DECLINE this consent, not authorizing anyone else to have access to my child's information.**

THIS CONSENT IS VALID FOR 2 YEARS FROM DATE SIGNED, UNLESS REVOKED BY PARENT.

Parent Name:_____Phone #: _____

Signature:_____Date: _____