

**LOWRY PEDIATRICS**

I, \_\_\_\_\_ (parent/guardian) give consent to \_\_\_\_\_ to make medical decisions regarding the treatment of \_\_\_\_\_ (patient name), in the event of my absence. This consent is dated today and is valid through \_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name/ Your relationship to the patient \_\_\_\_\_

Child's Name \_\_\_\_\_