Pediatric Dream Care
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Palm Springs, Fl 33461
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MEDICAL TREATMENT AUTHORIZATION AND CONSENT

Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized. This is to Authorize other individuals to bring your children to our office.

I, _____ (Full Legal Name of Parent/Guardian), being the parent/legal guardian of:

1. Child's full name: _____ DOB: ____/ ____/ _____
2. Child's full name: _____ DOB: ____/ ____/ _____
3. Child's full name: _____ DOB: ____/ ____/ _____
4. Child's full name: _____ DOB: ____/ ____/ _____
5. Child's full name: _____ DOB: ____/ ____/ _____

Authorize,

1. Caregiver's full name: _____ Relationship to patient: _____
2. Caregiver's full name: _____ Relationship to patient: _____
3. Caregiver's full name: _____ Relationship to patient: _____

To seek, obtain and consent to routine medical care and treatment/emergency medical care and treatment, procedures, and vaccinations for my child/children listed above as deemed necessary by a licensed medical or healthcare professional. This authorization is for the period when my child is in the care of the person/people listed above and is effective_____(date). I may revoke/edit this consent at any time.

_____	_____	____/ ____/ _____
Parent/guardian's name (print)	Parent/guardian's Signature	Date
_____	_____	____/ ____/ _____
Staff name (print)	Staff signature	Date