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Roger Abiragi, M.D. *Kevin Kutskill, M.D.* *Carol Abiragi, M.D.*
Leo Moschouris, M.D. *Nicole Beliveau, M.D.* *Amber Sikorski, D.O.*

CONSENT FOR MEDICAL TREATMENT

We are currently updating our medical records regarding consent of medical care in the absence of a parent/legal guardian.

I_____, give the below named individuals my permission

	Child's First/Last Name	**Date of Birth**
to bring my ***child(ren)***,	_____,	_____
	_____,	_____
	_____,	_____

to the Pediatric Clinic for evaluation and treatment by the physicians; including authorizing and signing for immunization administration in my absence. The physicians who care for my child, may also disclose health information regarding evaluation and treatment of my child to the ***below named individuals***.

_____	_____
Name	Relationship to child
_____	_____
Name	Relationship to child
_____	_____
Name	Relationship to child
_____	_____
Name	Relationship to child

It is the responsibility of the parent/guardian to inform Pediatric Clinic of any changes to this list of individuals.

_____	_____
Signature of Parent or Guardian	Date