

CHESTNUT PEDIATRICS
MEDICAL TREATMENT AUTHORIZATION AND CONSENT

I, _____, being the parent/legal guardian of:
Parent's Full Legal Name

- | | | |
|----|-------------------|-------|
| 1. | _____ | _____ |
| | Child's Full Name | DOB |
| 2. | _____ | _____ |
| | Child's Full Name | DOB |
| 3. | _____ | _____ |
| | Child's Full Name | DOB |
| 4. | _____ | _____ |
| | Child's Full Name | DOB |

Authorize:

- | | | |
|----|------------------------|-------------------------|
| 1. | _____ | _____ |
| | Full Name of Caregiver | Relationship to Patient |
| 2. | _____ | _____ |
| | Full Name of Caregiver | Relationship to Patient |
| 3. | _____ | _____ |
| | Full Name of Caregiver | 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 immediately. I may revoke/edit this consent at any time.

_____ Print Name of Parent/Guardian	_____ Signature of Parent/Guardian	_____ Date
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_____ Print Name of Parent/Guardian (Only sign and date if no change from previous year)	_____ Signature of Parent/Guardian	_____ Date
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_____ Print Name of Parent/Guardian (Only sign and date if no change from previous year)	_____ Signature of Parent/Guardian	_____ Date
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_____ Print Name of Staff Member	_____ Signature of Staff Member	_____ Date
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