

PEDIATRIC ASSOCIATES

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LEE'S SUMMIT
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AUTHORIZATION for MEDICAL CARE

I _____ hereby authorize the following individuals:

Name of Parent of Guardian

A. _____

Name of Representative

B. _____

C. _____

D. _____

To give consent for treatment for the following children in the event of illness or injury:

A. _____

Name of Child

B. _____

C. _____

D. _____

My child's doctor is: _____

Signature _____

Relationship _____

Date _____

Witness _____