Pediatric Associates, P.C.
FAX: 602-371-8929

Consent To Treat

Date: _____ (valid for the day) OR Date: _____ (valid for 6 months)

Consent from Parents or Guardians for Authorized Persons:

As the parent or guardian of _____. I am granting permission for the below listed person(s) to bring my child in for treatment and /or care.

Please select one of the following choices:

I am granting full permissions, meaning the below listed person(s) will be allowed to agree to treatments/vaccines, and know all health history pertaining to my child.
_____ **Initials.**

I am granting permissions, meaning the below listed person(s) is only allowed to bring my child in, and will have access to all health history, but not allowed to agree to treatments without my direct consent.
_____ **Initials.**

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

_____ Parent/Guardian Signature

_____ Date