Eastside Pediatric Group, LLP

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AUTHORIZATION

FOR MEDICAL TREATMENT OF MINORS

_____

NAMES OF MINORS BIRTHDATES IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

_____

_____

_____

_____

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

_____

NAME ADDRESS PHONE

_____

NAME ADDRESS PHONE

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/absence from:

_____through_____

MONTH DAY YEAR MONTH DAY YEAR

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

_____ _____

Signature of Parent/Guardian Date Signature of Parent/Guardian Date

_____ _____

Address Address

_____ _____

Witness Signature Date Witness Signature Date

_____ _____

Witness Address Witness Address