

Date _____ Child _____

AUTHORIZATION TO PROVIDE MEDICAL CARE

TO ANY HOSPITAL OR MEDICAL PROVIDER:

This document constitutes my authorization and consent for you to provide any and all medical and nursing care which you deem necessary or appropriate and in the best interest of my child:

Child's Full Name: _____

Date of Birth(Month/Day/Year): _____/_____/_____

I represent to you that I have legal authority to authorize and to consent to such medical care. I further authorize the bearer of this document to execute on my behalf any and all Consent to Treatment forms, including informed consent forms for invasive procedures, which you may require as a condition of treatment.

This authorization is effective this _____ day of _____, 20____ and shall remain in effect until I provide you with written notice of revocation.

My child's personal pediatric group is: **Parkside Pediatrics**

Physician's Name: _____

Address: 211 Batesville Road, Simpsonville, SC 29681

Tele: 864.272.0388

My child's insurance information is:

Insurer/HMO/PPO: _____ Policy #: _____ Group #: _____

Name of Insured: _____

My child's **ALLERGIES** are: _____

My child's **SIGNIFICANT MEDICAL CONDITIONS** and/or **RECENT INJURIES** are: (use back of form if necessary)

Date of my child's last tetanus shot: _____

A copy of this Authorization shall have the same force and effect as the original.

Signature: _____

Print Name: Relationship to child: _____

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Emergency contact other than parent:

Name: _____ Phone: (_____) _____