AUTHORIZATION FOR MEDICAL TREATMENT OF CHILDREN
prepared for

Pediatric Consultants of Troy, P.C.

44199 Dequindre Road, Suite 222, Troy, MI 48085 (248) 879-5570
50720 Schoenherr Road, Shelby Township, MI 48315 (586) 566-2340

I/We being the undersigned or legal guardian of the following minor(s):

Name of Minor: _____

Birth date: _____ Male / Female

Allergies or Special Conditions:

_____

_____

Do hereby appoint either of the following:

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip:_____ City/State/Zip:_____

Phone Number: (_____) _____ Phone Number: (_____) _____

To act in my behalf in authorizing medical, surgical or hospitalization for the above named minor during the period of my absence.

IN NO EVENT SHALL THE DELEGATION OF PARENTAL RIGHTS BE EFFECTIVE FOR MORE THAN ONE YEAR.

Parent/Guardian: _____ Date: _____

Signature

Parent/Guardian: _____ Date: _____

Signature

Appointed Representative of Parent/Guardian: _____ Date: _____

Appointed Representative of Parent/Guardian: _____ Date: _____