Pediatric Consultants of Troy
633 E. South Blvd. Suite 2400 Rochester Hills, MI. 48307 (248) 879-5570
50720 Schoenherr Road Shelby Twp., MI. 48315 (586) 566-2340

AUTHORIZATION FOR MEDICAL TREATMENT OF CHILDREN

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

Name of Minor(s): ____ DOB: ____________

____ DOB: ____________

____ DOB: ____________

Allergies or Special Conditions: ____

Do hereby appoint either of the following:

Name: ____

Address:____

Phone:____

Name:____

Address:____

Phone:____

To act on my behalf in authorizing medical treatment <u>for non-routine appointments only, i.e. sick appointments</u>. Legal guardians may be contacted if necessary. Authorization is subject to change at discretion and is valid for one years time.

Parent Guardian: ____________________________ Parent Guardian: ______________________

(Name) (Signature)

Date: ______________________________________ Date: ________________________________

Appointed Representative of Parent/ Guardian: _____________________________ Date: ______

Appointed Representative of Parent/ Guardian: _____________________________ Date: ______

Updated 1/2022