

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 for non-routine appointments only, i.e. sick appointments. Legal guardians may be contacted if necessary. Authorization is subject to change at discretion and is valid for one year.

Parent Guardian Name & Relationship: _____

Parent Guardian Signature: _____

Date: _____