Chestnut Pediatrics
Medical Treatment Authorization and Consent

I, _____ (Full Legal Name of Parent/Guardian), being the parent/legal guardian of

1. _____ _____
   Child's Full Name DOB
2. _____ _____
   Child's Full Name DOB
3. _____ _____
   Child's Full Name DOB
4. _____ _____
   Child's Full Name DOB

authorize,

1. _____ _____
   Full Name of Caregiver Relationship to Patient
2. _____ _____
   Full Name of Caregiver Relationship to Patient
3. _____ _____
   Full Name of Caregiver Relationship to Patient

to seek, obtain and consent to routine medical care and treatment/emergency medical care and treatment, procedures and vaccinations for my child/children listed above as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of the person/people listed above and is effective _____ (Date). I may revoke/edit this consent at any time.

_____/_____/_____
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

_____/_____/_____
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**
(Only sign and date if no change from previous year)

_____/_____/_____
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**
(Only sign and date if no change from previous year)

_____ _____
Signature of Office Staff **Date**