NORTH PINELLAS
Children's Medical Center
Board Certified Pediatricians

# Authorization to Consent to Treat a Child

I (we) _____
Name(s) and address(es) of parents

designate _____
Name and address of designee

the power to consent in our absence to medical care for our child(ren):

_____ _____
Name and age of child Name and age of child

_____ _____
Name and age of child Name and age of child

Parent(s) phone number: _____
Child(ren)'s physician(s): _____
Physician's address and phone number: _____
_____
Medical insurance company: _____
Policy #: _____ Group #: _____
Dates of expected absence from _____ to _____

**CHILD(REN)'S MEDICAL HISTORY**

Chronic conditions_____

Medications that need to be given on a regular basis:

_____ _____
Child's Name Medication name, dosage, frequency

_____ _____
Child's Name Medication name, dosage, frequency

_____ _____
Child's Name Medication name, dosage, frequency

_____ _____
Child's Name Medication name, dosage, frequency

Allergies: _____
Dietary or other restrictions: _____

Parent Signature:_____
Date:_____

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