Associated Pediatric Partners, S.C.

M. Belinda Radis, M.D.
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MEDICAL PERMISSION TO TREAT MINOR CHILD

Minor Details:

Full legal name_____

Date of Birth: _____

I, _____, parent or legal guardian of the aforementioned Minor, hereby grant authorization and provide consent for _____ (hereafter "Designated Adult"), or for the minor without accompanying adult, to obtain routine medical examinations, treatment, procedures, vaccinations, diagnosis, and medication on behalf of the Minor in my absence. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult, or unaccompanied Minor, to summon any and all professional emergency personnel to attend, transport and treat the Minor.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult/Minor in the exercise of his or her best judgment upon the advice of any licensed physician.

This authorization will be in effect until revoked in writing by parent or legal guardian, or until minor reaches 18 years of age.

Today's Date: _____

Parent/Legal Guardian Signature _____ Printed Name_____

Phone number where guardian/custodial parent can be reached_____