MOUNTAINLAND
PEDIATRICS

AUTHORIZATION FOR CHILD'S TREATMENT

I am the parent/guardian of _____,DOB _____

I hereby give Mountainland Pediatrics specific authorization to treat my child, including authorization to administer immunizations, when my child is brought to the practice by any of the following caregivers.

I further authorize the practice to triage or discuss with the designated caregivers, either in person or by phone, my child's symptoms and/or medical condition in order to assist and advise the caregiver concerning the immediate treatment options for my symptomatic child. This includes releasing relevant medical information to the caregiver, on a need to know basis

Please indicate name and relationship to patient:

Name _____Relationship_____

Name _____Relationship_____

Name _____Relationship_____

Name _____Relationship_____

Name _____Relationship_____

Name _____Relationship_____

_____ _____

Parent/Guardian Date

12/4-09