PEDIATRIC & ADOLESCENT MEDICINE
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Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

This is a permission form for adults (18yrs and older) other then the parents or legal guardians to bring the child(ren) to the office for medical care, and to give consent for medical treatment.

The purpose of this form is to allow you, the parent, the option of naming other adults to bring your child(ren) to the office of Bakersfield Pediatrics for medical evaluations and treatment. You will be giving permission for these adults to discuss your child's personal medical history with the staff of Bakersfield Pediatrics as needed and to make any medical decisions needed at the time of the appointment, not excluding any medical emergencies.

This authorization will be valid from _____to_____, and must be renewed annually.

Date	Parent	Name of Adult	Relationship to child(ren)

This form may be modified in writing at any time at the request of the parent. To remove an adult from this list parent must do so in the office.

_____ _____
Print name of Parent/Legal Guardian Relationship to child(ren)

_____ _____
Signature Date

Revised 2014-10-02