Community
Physicians of Indiana

Parent/Legal Guardian Authorization for Medical Care for Child

Name of Child: ______________________________

Date of Birth: ______________________________

I (We) ______________________________ grant ______________________________
Parent/Legal Guardian Person Accompanying Child
permission to seek medical care and consent to treatment as deemed necessary to the above named dependant in my absence. The care will be given at the office of

______________________________.
Name of Physician and/or Practice

Parent/Legal Guardian Signature: ______________________________

Date: ______________________________