Authorization of Medical Treatment of a minor child in the absence of parent or legal guardian.

By my signature below and as the parent or legal guardian of:

(Child)_____DOB:_____

I hereby authorize Katz Pediatrics, to treat my child when I am unavailable. I further authorize the following person(s) to bring my child to Katz Pediatrics for medical attention if necessary.

The person(s) that I authorize to bring my child in for treatment in my absence are:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This consent is valid unless I revoke it in writing stating otherwise.

_____ _____ _____

Signature of Parent or Legal Guardian Relation to patient Date