DR.EISNER
PEDIATRICIAN

Parental Authorization
Consent to Medical Treatment for Child

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

I, _____ am the parent having legal custody of child (ren) listed below. While being absent from my child (ren) I have entrusted his/her/their care to:

Name: _____ Relationship to patient:_____
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

I authorize the adult(s) listed above to consent to routine pediatric well care including immunizations, medical evaluation and management, minor in-office procedures, and disclosure of any medical diagnosis and treatment.

- If any changes need to be made or form needs to update please alert our office.

_____ _____
Legal Guardian Signature: Date:

_____ _____
Witness (Sign and Print Name): Date: