Authorization to Treat

Parents or Guardians:

In the event you are unable to bring your child for care at Tulsa Pediatric Group, PC; please list who may bring your child for treatment. (i.e. stepparents, grandparents, babysitters, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This signed consent will allow Tulsa Pediatric Group, PC to provide the appropriately needed care for your child in the event of illness or an accident.

Please list **ALL** children who can be accompanied by the above-mentioned individuals.

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

This consent shall expire one year from the date the form was completed.

_____

PRINT PARENT/GUARDIAN NAME

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

TULSA PEDIATRIC GROUP, PC
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