

**Authorization for medical treatment
Of a minor child in absence of parent/legal guardian**

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

_____ DOB: _____
Name of Minor Child

I hereby authorize **Kid's Place Pediatrics PA** Provider to treat my child when I am unavailable. I further authorize the following person(s) to bring my child to Kid's Place Pediatrics for medical attention if necessary. I understand and have communicated to each person that their personal identification documents must be available for inspection by KPP staff each time they accompany my child for a medical visit.

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

_____ Relationship: _____
Name

_____ Relationship: _____
Name

_____ Relationship: _____
Name

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

Print Name

Relationship to patient

Signature

Date

Name of Witness

Title