LAKEVIEW PEDIATRICS, LLC

AUTHORIZATION FOR CONTACT OR TREATMENT

I, _____ authorize _____ to act on my behalf regarding my child(ren) as specified below.

_____ DOB: _____/_____/_____

_____ DOB: _____/_____/_____

_____ DOB: _____/_____/_____

_____ DOB: _____/_____/_____

_____ DOB: _____/_____/_____

☐ Call the office and give and receive medical information.

☐ Bring my child to the office for a scheduled appointment, give and receive information and make medical decisions in the event I am unable to be reached.

☐ This includes signing the consent form for regularly scheduled vaccines in the event I am not present.

☐ To act on my behalf in the event I cannot be reached when seeking emergency medical treatment including that in the emergency room.

_____
Parent/Guardian Name (please print)

_____ _____/_____/_____
Parent/Guardian Signature Date

Contact Number(s):

1. (_____) _____-_____
2. (_____) _____-_____
3. (_____) _____-_____
4. (_____) _____-_____

This document is valid from

_____-_____.

If not specified it will be valid for one year after date signed.