Stonebridge Pediatrics

Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Tara Williams, R.N., C.P.N.P.

Consent for Medical Care

I,_____(parent/legal guardian), cannot accompany my child,_____(child's name), to Stonebridge Pediatrics. Therefore, I give permission to _____(person's name& relation -example: Step-parent, grandparent, relative, or someone over the age of 18.). _____(relationship to child) as follows (check one):

[ ] I give permission for this person to seek medical treatment (including any type of procedure, vaccinations/injections, or in office treatments) and provide consent for such treatment if attempts to contact me are unsuccessful.

[ ] I give permission for this person to seek medical treatment (including any type of procedure, vaccination/injections, or in office treatments) and provide consent for such treatment without having to contact me.

[ ] I give permission to speak with _____in regards to all medical diagnosis and treatments.

Please note this consent does NOT have an expiration date. If at any time you wish to revoke privileges for any individual, you must do so in writing to our office immediately. If you wish to have this person listed as short term, please include an expiration date in the space below. (Effective date must be completed.)

Effective Date:_____ / Expiration Date:_____.

._____.

(Signature of parent or legal guardian) (Date)