

# CENTRAL FLORIDA PEDIATRICS CONSENT FOR CARE

I, \_\_\_\_\_, the parent/legal guardian of the following patients:

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Initial: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Initial: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Initial: \_\_\_\_\_

hereby give authorization for \_\_\_\_\_ to bring my child to Central Florida Pediatrics. This person has my permission to discuss my child's medical conditions, past and present, and give consent for any treatment deemed necessary.

I understand this consent will expire December 31<sup>st</sup> and a new consent is required each calendar year.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

- Personally known
- Identification produced \_\_\_\_\_

Notary: \_\_\_\_\_

(SEAL)