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 the following people to bring my child to Central Florida Pediatrics and to discuss my child's medical conditions, past and present, and give consent for any treatment deemed necessary.

Name: _____ Expires: _____

Name: _____ Expires: _____

Name: _____ Expires: _____

_____ _____
Signature of Parent/Guardian Date

FOR OFFICE USE ONLY:

_____
Print Employee's Name

_____ _____
Employee's Signature Date

_____
Parent I.D. Expiration Date