



Statement of Permission to Treat

Date

To Whom It May Concern:

I am the parent of:

_____	_____
_____	_____
_____	_____

I give permission to the following listed person(s) to obtain medical treatment for the above- referenced child(ren) with a provider of MD Pediatric Associates or any facility which the provider deems necessary. This person(s) has my permission for medical decision making including but not limited to: administration of medication, administration of immunization, diagnostic or therapeutic procedures, admission to the hospital, etc. I will be responsible for payment for care. This permission remains in effect until I sign a document rescinding this permission.

Name:

Relationship to child:

_____	_____
_____	_____
_____	_____
_____	_____

In an emergency, the parent(s) may be reached at:

Phone

Parent Signature